Your Retiree Health Benefit Program

Summary Plan Description

INTERNATIONAL

HW 369

Navistar, Inc.
2601 Navistar Drive
Lisle, IL 60532 USA

P: 1- 877-353-5100

Date: October 2023

To: All Retirees and Surviving Spouses in the Navistar, Inc. Retiree Medical Plan

Subject: Details regarding the premiums, deductibles, out-of-pocket maximums and prescription drug co-payments for the year 2024

Under the Settlement Agreement, the monthly contributions or "premiums" that you must pay to participate in the Health Benefit program are required to change each year. Factors that are taken into account are inflation and Plan experience. In addition, the deductibles and out-of-pocket maximums for retirees and surviving spouses are scheduled to increase by 6% each year.

As you may recall, the Settlement Agreement established a Supplemental Trust that is governed by a Committee of five individuals, all of whom are independent from the Company. The Trust was initially funded by the contribution of approximately 25.6 million shares of Navistar International Corporation's Class B Common Stock. The Trust subsequently sold all of that stock and has used some of the proceeds to provide additional benefits to plan members and has reinvested the remainder in other investments. In addition to income from such investments, the Trust may also receive profit sharing payments from the Company based on a formula described in the Settlement Agreement.

For 2024, the Navistar, Inc. Supplemental Benefit Committee has decided to use funds in the Trust to buy down, and in some cases eliminate, increases in health care premiums, deductibles, and out-of-pocket maximums for retirees. This action by the Supplemental Trust Committee reduces those cost-sharing items that retirees would otherwise be obligated to pay. The Supplemental Trust Committee has also decided to use funds in the Trust to reduce the prescription drug co-payments that retirees would otherwise be obligated to pay.

Starting in 1999, the Supplemental Trust began providing dental, vision and hearing aid coverage to plan members and, starting September 19, 2000, it began restoring up to $5,000 of the life insurance coverage for retired employees that had been reduced under the Settlement Agreement. It will continue those benefits for 2024.

The January 1, 2024, premiums and out-of-pocket deductibles and maximums are detailed in the charts that follow. The tables show the scheduled amounts for premiums, deductibles, out-of-pocket maximums and drug co-payments and how the actions of the Supplemental Trust Committee have reduced your share of the health care costs. We will keep you informed of any changes.

DEDUCTIBLES

Year	(Medicare & Non-Medicare)	Actual
1993	$ 200.00	$ 200.00
1994	$ 212.00	$ 200.00
1995	$ 225.00	$ 200.00
1996	$ 238.00	$ 200.00
1997	$ 252.00	$ 214.00
1998	$ 267.00	$ 0
1999	$ 284.00	$ 0
2000	$ 301.00	$ 0
2001	$ 319.00	$ 0
2002	$ 338.00	$ 0
2003	$ 358.00	$ 0
2004	$ 380.00	$ 200.00
2005	$ 403.00	$ 200.00
2006	$ 427.00	$ 200.00
2007	$ 453.00	$ 200.00
2008	$ 480.00	$ 200.00
2009	$509.00	$ 200.00
2010	$539.00	$ 400.00
2011	$571.00	$ 400.00
2012	$606.00	$ 400.00
2013	$642.00	$ 400.00
2014	$681.00	$ 400.00
2015	$721.00	$ 400.00
2016	$765.00	$ 400.00
2017	$811.00	$ 600.00
2018	$859.00	$ 859 Medicare $600.00 Non-Medicare
2019	$910.00	$910 Medicare $600.00 Non-Medicare
2020	$964.00	$ 600.00
2021	$1,022.00	$ 600.00
2022	$1,084.00	$ 0.00
2023	$1,149.00	$ 0.00
2024	**$1,218.00**	**$ 0.00**

OUT-OF-POCKET MAXIMUMS

Year	Scheduled Out-of-Pocket Maximum (Non-Medicare Only)	Actual
1993	$500.00	$500.00
1994	$530.00	$500.00
1995	$562.00	$500.00
1996	$596.00	$500.00
1997	$632.00	$536.00
1998	$670.00	$322.00
1999	$709.00	$322.00
2000	$752.00	$322.00
2001	$797.00	$322.00
2002	$845.00	$322.00
2003	$896.00	$322.00
2004	$949.00	$522.00
2005	$1,006.00	$522.00
2006	$1,066.00	$522.00
2007	$1,130.00	$522.00
2008	$1,198.00	$522.00
2009	$1,270.00	$522.00
2010	$1,346.00	$522.00
2011	$1,427.00	$522.00
2012	$1,513.00	$722.00
2013	$1,604.00	$722.00
2014	$1,700.00	$722.00
2015	$1,801.00	$722.00
2016	$1,910.00	$722.00
2017	$2,025.00	$1,000.00
2018	$2,147.00	$1,000.00
2019	$2,275.00	$1,000.00
2020	$2,411.00	$1,000.00
2021	$2,556.00	$1,000.00
2022	$2,709.00	$ 400.00
2023	$2,872.00	$ 400.00
2024	**$3,044.00**	**$ 400.00**

HEALTH CARE PREMIUMS

Year	Scheduled Premiums		Actual	
	Plan 1 Non-Medicare	Plan 2 Medicare	Plan 1 Non-Medicare	Plan 2 Medicare
1995	$53.25	$25.86	$53.25	$25.86
1996	$64.45	$31.30	$53.25	$25.86
1997	$66.99	$32.53	$55.79	$27.09
1998	$61.64	$29.94	$50.00	$25.00
1999	$56.60	$27.49	$50.00	$25.00
2000	$60.73	$29.50	$50.00	$25.00
2001	$66.94	$32.51	$50.00	$25.00
2002	$81.36	$39.52	$50.00	$25.00
2003	$83.36	$40.49	$50.00	$25.00
2004	$92.22	$44.79	$50.00	$25.00
2005	$106.17	$51.57	$50.00	$25.00
2006	$108.40	$52.65	$50.00	$25.00
2007	$104.82	$50.91	$50.00	$25.00
2008	$117.34	$56.99	$50.00	$25.00
2009	$125.37	$60.90	$50.00	$25.00
2010	$128.96	$62.64	$54.00	$27.00
2011	$131.64	$63.94	$56.68	$28.30
2012	$71.01	$34.49	$40.68	$20.30
2013	$126.58	$61.48	$51.62	$25.84
2014	$190.85	$92.70	$71.62	$35.84
2015	$137.53	$66.80	$62.57	$31.16
2016	$189.14	$91.87	$71.62	$35.84
2017	$213.65	$103.77	$71.62	$35.84
2018	$205.07	$99.60	$71.62	$22.26
2019	$214.15	$104.02	$71.62	$22.26
2020	$207.20	$100.64	$71.62	$22.26
2021	$196.03	$ 95.21	$71.62	$22.26
2022	$ 73.62	$ 35.76	$ 5.00	$ 5.00
2023	$ 9.37	$ 4.55	$ 5.00	$ 4.55
2024	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**

DRUG CO-PAYS—RETAIL (PHARMACIES) PER 30 DAY SUPPLY

Year	Generic Co-pay	Brand Co-pay
7/1/1993 - 6/30/1995	$ 8.00	$ 18.00
7/1/1995 - 12/31/95	$ 6.00	$ 16.00
1996 through 1999	$ 5.00	$ 15.00
2000 through 2003	$ 2.00	$ 5.00
2004 through 2023	$ 5.00	$ 12.00
2024	**$ 5.00**	**$ 12.00**

DRUG CO-PAYS—MAIL ORDER

Year	Generic Co-pay	Brand Co-pay
7/1/1993 - 6/30/1995	$ 7.00 *	$ 7.00 *
7/1/1995 - 12/31/95	$ 5.00 *	$ 5.00 *
1996 through 1999	$ 4.00 *	$ 4.00 *

** For years 1993 through 1999, the amounts shown were the co-pays per each 30-day supply. Therefore, for those years, the co-pays for a 90-day supply were three times the amounts shown for a 30-day supply.*

2000 through 2003	$ 0	$ 0
2004 - 2024	**$ 4.00**	**$ 7.00**
For up to a 90-day supply		

OFFICE VISIT DEDUCTIBLE

In July 2005, a physician office service benefit was added under the Shy Medical Plan 1 in order to provide you with access to discounts when seeking treatment from Aetna PPO network providers.

To accomplish this, physician office services (i.e., services performed in an office setting other than x-ray and lab charges) with a date of service on or after July 1, 2005, which were formerly not covered, became subject to a separate calendar year deductible. This deductible was $1,500 for 2005 and 2006. This deductible applies separately to each member in the plan. After 2006, this deductible is subject to change based upon the current medical trend. The following chart outlines the deductible:

Year	Actual
7/1/2005	$ 1,500.00
1/1/2006	$ 1,500.00
1/1/2007	$ 1,620.00
1/1/2008	$ 1,798.00
1/1/2009	$ 1,996.00
1/1/2010	$ 2,255.00
1/1/2011	$ 2,559.00
1/1/2012	$ 2,848.00
1/1/2013	$ 3,130.00
1/1/2014	$ 3,466.00
1/1/2015	$ 3,826.00
1/1/2016	$ 4,163.00
1/1/2017	$ 4,529.00
1/1/2018	$ 4,928.00
1/1/2019	$ 5,312.00
1/1/2020	$ 5,726.00
1/1/2021	$ 6,173.00
1/1/2022	$ 6,654.00
1/1/2023	$ 7,173.00
1/1/2024	**$ 7,711.00**

After the applicable calendar year deductible has been met per member, a per member co-insurance expense of 50% for network physicians or a per member co-insurance expense of 80% of the reasonable and customary charge for out-of-network physicians will apply. Your out-of-pocket expenses that are applied toward meeting this deductible and co-insurance expense (1) will only apply to physician office service expenses performed in an office setting (excluding any x-ray and lab charges and other health care services, such as surgery, outpatient or inpatient fees), and (2) will not count towards your general annual deductible, co-payment maximum, or out-of-pocket maximum under the plan.

If you have relatives or residents of your household who do not qualify as regular dependents, but are dependent on you for more than one-half of their support as defined by the Internal Revenue Service, they may be eligible for coverage as sponsored dependents. The premium for sponsored dependent coverage is the full cost of the plan. The full cost of Plan 1 (non-Medicare) for the year 2024 is **$1,137.07** per month. The full cost of Plan 2 (Medicare) for 2024 is **$394.06** per month. You may add sponsored dependents to your coverage as long as you enroll them within 31 days after they become eligible for coverage and you pay the full premium cost; otherwise, you may enroll sponsored dependents during the annual enrollment period designated by the Company. **The annual enrollment period for the year 2024 coverage is October 25 - November 8, 2023.** Please call Navistar's P&C Connection Network at 1-877-353-5100.

INTERNATIONAL TRUCK AND ENGINE CORPORATION
4201 WINFIELD, P.O. BOX 1488, WARRENVILLE IL 60555

Date: July 11, 2005

To: All Employees, Retirees and Surviving Spouses of International Truck and Engine and its subsidiaries

Subject: New Specialty Pharmacy Program

International Truck and Engine Corporation is pleased to annouce a new program that provides high quality, personal health and pharmacy services for "Specialty Pharmaceuticals" that you or a family member are being prescribed or may need in the future. Please note this new program does not affect your coverage for most prescription drugs, but does give attention to a special group of medications. "Specialty Pharmaceuticals" are a unique category of drugs, derived from advances in drug development research, technology and design that targets and treats chronic or genetic conditions. Some examples of such conditions and common specialty medications would be: *Procrit for treating Anemia; Lupron medication for Cancer treatment; Multiple Sclerosis drugs of Avonex and Copaxone; Enbrel or Humira medication for Rheumatoid Arthritis and Pegasys for treating Hepatitis C.* For a complete list of medications that are included in this program, please refer to the enclosed attachment.

Beginning April 1, 2005, Caremark Specialty Pharmacy Services will be International's exclusive provider for specialty medications for non-HMO health care participants. Caremark has a dedicated pharmacy and service department that provides you with:

- Personal attention for patient's unique needs
- Condition-specific education and training
- 24 hours a day, 7 days a week pharmacists assistance
- Ease of delivery of medication to the location of your choice
- Care coordination with your physician
- Proactive refill reminders

How does this program work?

Current Participants

If you or a member of your family is currently taking a specialty medication, Caremark will mail a letter to your home and contact your physician to facilitate the transfer of your prescription to Caremark Specialty Pharmacy Services. A CaremarkConnect representative will follow up with you, by phone, as necessary. The only action you need to take is to continue to pay your prescription drug co-payment according to your plan of benefits. Caremark and your physician will handle your treatment and services jointly to give you the highest level of care. You will continue to see your physician as scheduled, however you will also receive some personal engagement from Caremark for education, discussion about any clinical reactions to the medication and assistance at refill time.

Future Participants

If in the future, your physician initiates a drug therapy for a specialty medication, your physician will verify your prescription drug benefits and provide you with a prescription. To easily obtain the specialty medication, you would simply call the toll-free phone number the retail pharmacist will provide to you or send the prescription in through the Caremark mail order process. A CaremarkConnect representative will follow up with you, by phone, as necessary. In addition to submitting your prescription, you will need to pay your prescription drug co-payment according to your plan of benefits. Caremark and your physician will handle your treatment and services jointly to give you the highest level of care. You will continue to see your physician as scheduled but in addition, will also receive some personal engagement from Caremark for education, discussion about any clinical reactions to the medication and assistance at refill time.

We are confident this new program will bring to you the convenience and satisfaction you expect so you can concentrate on improving your health. If you have any questions about this program, please contact Caremark at 1-866-559-6851.

Sincerely,
International Truck and Engine Corporation

International Truck and Engine Corporation
Specialty Pharmacy Program Drug List
Effective April 1, 2005

ACTIMMUNE®
ADALIMUMAB
ADVATE™
AGALSIDASE BETA
ALDURAZYME®
ALEFACEPT
ALPHA-1-PROTEINASE
ALPHANATE SD®
ALPHANINE SD®
AMEVIVE®
ANAKINRA
ANTIHEMOPHILIC FACTOR
ANTIHEOMPHILIA FACTOR
ANTI-INHIBITOR COAGULANT COMP.
ARALAST™
ARANESP®
AUTOPLEX T®
AVONEX®
BAYGAM®
BEBULIN VH®
BENEFIX®
BETASERON®
BOSENTAN
CAPECITABINE
CARIMUNE® NF
CEREZYME®
CINACALCET HCL
COPAXONE®
COPEGUS®
CYTOGAM®
CYTOMEGALOVIRUS
DARBEPOETIN ALFA IN
DESMOPRESSIN ACETATE
DORNASE ALFA
EFALIZUMAB
ENBREL®
ENBREL®
ENFUVIRTIDE
EPOETIN ALFA
EPOGEN®
EPOPROSTENOL NA
ETANERCEPT
FABRAZYME®
FACTOR IX
FEIBA VH®
FILGRASTIM
FLEBOGAMMA®
FLOLAN®
FORTEO®
FUZEON®
GAMIMUNE N®
GAMMAGARD S/D®
GAMMAR-P IV®
GAMUNEX®
GEFITINIB
GENARC®
GENOTROPIN®
GLATIRAMER ACETATE
HELIXATE FS®
HEMOFIL M HU®
HUMATE-P®
HUMATROPE®
HUMIRA®
IMATINIB MESYLATE
IMIGLUCERASE
INFERGEN®
INFLIXIMAB
INTERFERON ALFACON-1
INTERFERON BETA
INTERFERON GAMMA
IVEEGAM® EN
KINERET®
KOATE-DVI®
KOGENATE FS®
LARONIDASE
LEUKINE®
MITOXANTRONE HCL
MONARC M®
MONOCLATE-P®
MONONINE®
NEULASTA®
NEUMEGA®
NEUPOGEN®
NORDITROPIN®
NOVANTRONE®
NOVOSEVEN®
NUTROPIN AQ®
NUTROPIN®
OCTAGAM®
OMALIZUMAB
OPRELVEKIN
PALIVIZUMAB
PANGLOBULIN®
PEGASYS®
PEGFILGRASTIM
PEGINTERFERON ALFA-2A
PEGINTERFERON ALFA-2B
PEG-INTRON®
POLYGAM S/D®
PROCRIT®
PROFILNINE®
PULMOZYME®
RAPTIVA®
REBETOL®
REBETRON®
REBIF®
RECOMBINATE™
REFACTO®
REMICADE®
REMODULIN®
RIBASPHERE™
RIBAVIRIN
RIBAVIRIN/INTERFERON A-
SAIZEN®
SARGRAMOSTIM
SENSIPAR®
SEROSTIM®
SOMATROPIN
STIMATE®
SYNAGIS®
TEMOZOLOMIDE
TERIPARATIDE
THALIDOMIDE
THYROGEN®
THYROTROPIN ALFA
TOBI®
TOBRAMYCIN/NA CHLOR
TRACLEER®
TREPROSTINIL SODIUM
XOLAIR®
ZORBTIVE ™

Note: The drugs on this list are subject to updates of new Specialty Pharmcy Products and by careful review from International Truck and Engine's Medical Department.

SUMMARY OF BENEFIT CLAIM AND APPEAL PROCEDURES
EFFECTIVE NOVEMBER 1, 2002, AS AMENDED NOVEMBER 15, 2006

This Summary of Material Modification explains the new rules that govern claim and appeal procedures under the PPO and Indemnity coverage options offered under the International Truck and Engine Corporation Retiree Health Benefit Program (the "Plan"), negotiated as part of the settlement reached in *Shy v. Navistar*; except that this Summary of Material Modification does **not** apply to or modify the benefit options made available under the retiree supplemental benefit program under the Plan, as administered by the Supplemental Benefit Committee. These rules are intended to comply with Section 503 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and apply to initial claims for benefits under the Plan made on or after November 15, 2006. If you are enrolled in an HMO coverage option offered under the Plan, please consult your HMO or HMO booklet for the rules that govern claim and appeal procedures under the Plan. Please keep this summary with your Summary Plan Description for future reference.

Initial Claims for Benefits

Your claims related to eligibility to participate in the Plan should be submitted in writing to International Truck and Engine Corporation, Attn: Employee/Retiree Information Center/Health Plan Specialist, P.O. Box 1097, Warrenville, IL 60555. The phone number is 1-877-353-5100.

Your claims under the Plan for medical expense benefits should be submitted in writing to Aetna, Attn: National Account CRT, P.O. Box 14463, Lexington, KY 40512. The phone number is 1-800-435-2969.

Your claims under the Plan for prescription drug benefits should be submitted in writing to Caremark, Inc., P.O. Box 686005, San Antonio, TX 78268-6005. The phone number is 1-866-559-6851.

Claims must be submitted no later than one year following the date of service. Failure to file the claim within the one-year timeframe will not invalidate claims where it is shown that it was not reasonably possible or not practicable to file within such time. Your claim for benefits under the Plan should include any documentation (including relevant medical documentation) necessary in order to review your claim.

Notification of Benefit Determination – Special Rules

1. Urgent Care Claims. You will be notified of the Plan's decision on your claim for urgent care (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of your claim by the Plan, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, you will be notified as soon as possible, but not later than 24 hours after receipt of your claim by the Plan of the specific information needed to complete your claim. You will have at least 48 hours to provide the specified information. You will be notified of the Plan's benefit determination as soon as possible, but not later the 48 hours after the Plan's receipt of the specified information or, if earlier, the end of the period afforded you to provide the specified additional information. If your claim is denied, you will be notified in the manner set forth below.

2. Concurrent Care Claims. If the Plan has approved coverage for an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall be considered a denial of treatment. You will be notified in the manner set forth below of any denials of treatment at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on appeal of your denial before the benefit is reduced or terminated. If you request that your course of treatment be

extended beyond the period of time or number of treatments and it is a claim involving urgent care, you will be notified of the Plan's decision (whether adverse or not) on your claim within 24 hours after receipt of the claim by the Plan, provided that your claim is made to the Plan at least 24 hours prior to the expiration of your prescribed course of treatment. If your claim is denied, whether your claim involves urgent care or not, you will be notified in the manner set forth below.

3. Pre-Service Claims. You will be notified of the Plan's decision (whether adverse or not) on your pre-service claim not more than 15 days after receipt of your claim by the Plan. This period may be extended by the Plan for up to 15 days, provided that the Plan determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit information necessary to decide the claim, the notice of extension shall specifically describe the required information and you shall be afforded at least 45 days from the receipt of the notice within which to provide the specified information. If your claim is denied, you will be notified in the manner set forth below. In the event that a period of time is extended due to a failure to submit information necessary to decide your claim, the period of making the benefit determination shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

4. Failure to Follow Procedures in Filing a Pre-Service Claim. If you fail to follow the Plan's procedures for filing a pre-service claim, you will be notified of the failure and of the Plan's procedures for filing a pre-service claim as soon as possible, but not later than 5 days (24 hours if your claim is an urgent care claim) following the failure. This notification may be oral, unless you request written notification.

5. Post-Service Claims. You will be notified of the Plan's decision with respect to a post-service claim within 30 days of the receipt of your claim. This period may be extended one time for up to 15 days, provided that the Plan determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and you shall be given at least 45 days from the receipt of the notice to provide the specified information. In the event that a period of time is extended due to a failure to submit information necessary to decide your claim, the period of making the benefit determination shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

6. Authorized Representative. An authorized representative may act on your behalf in filing a claim and/or appeal under the Plan. The Plan will determine whether a person is actually authorized to act as your representative. However, if your claim is a claim for urgent care, a health care professional with knowledge of your medical condition shall be authorized to act on your behalf. Contact your Plan administrator for further details.

Manner and Content of Your Notification of Benefit Determination

1. Any notification of benefit determination will be provided in writing or in electronic media (such as email) in a manner easily understood by a reasonable layperson. Notification of benefit determination concerning urgent care claims may be provided orally with written or electronic notice furnished to you within 3 days after oral notice.

2. If your claim for benefits is denied, in whole or in part, your notice will: (i) state the specific reasons for your denial; (ii) state the specific Plan provisions on which your denial was based;

(iii) provide a description of any additional material or information necessary for you to perfect your claim and an explanation of why this material or information is necessary; (iv) include a description of the Plan's appeals process and the time limits applicable to such appeal, with a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of your appeal; (v) if your denial was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon your request; (vi) if your denial was based on an internal rule, protocol, guideline, or other similar criterion, such internal rule, protocol, or other similar criterion will be included or a statement that you may obtain a copy of such internal rule, guideline, protocol, or other similar criterion upon your request and free of charge will be included; and (vii) if your denial concerns an urgent care claim, your notification will provide you with a description of the Plan's expedited review process.

Appealing Your Denial

If your claim for benefits under the Plan was denied, in whole or in part, you will be given the chance to file an appeal on your claim. **However, you must make your appeal within one year of the date you receive the notice of claim denial. Failure to timely file your appeal will result in both your notice of claim denial being upheld and you being deemed to have exhausted your administrative remedies (other than your right to file a voluntary appeal, as described below) available under the Plan's claims procedures.** If a claim is denied under Plan 2 because Medicare did not cover the expense, you cannot appeal the denial unless Medicare reverses their initial denial of payment. You must timely file your request for appeal in writing (unless you request an expedited appeal of an urgent care claim, in which case the appeal may be submitted orally or in writing).

Request for Appeal

Your request for appeal related to eligibility to participate in the Plan should be submitted to International Truck and Engine Corporation, Attn: Employee/Retiree Information Center/Manager, Healthcare, P.O. Box 1097, Warrenville, IL 60555.

Your request for appeal of claims involving medical expense benefits should be sent to Aetna, Attn: National Account CRT, P.O. Box 14463, Lexington, KY 40512.

Your request for appeal of claims involving prescription drugs should be sent to Caremark, Inc., Appeals Department, MC109, P.O. Box 52084, Phoenix, Arizona 85072-2084or fax to 1-866-689-3092. The phone number is 1-866-559-6851.

Your appeal will provide you with a full and fair review which includes the following procedures:

(i) The opportunity to submit written comments, documents, records and other materials relating to your claim for benefits for review upon appeal. This information will be taken into account on appeal regardless of whether it was initially submitted with your claim.

(ii) The opportunity for reasonable access to and copies of, at your request and free of charge, any documents, records or other information relevant to your claim.

(iii) The review will not defer to any prior denial and will be conducted by a Plan fiduciary who is neither the individual who made the initial denial (or denial upon appeal), nor the subordinate of such an individual.

(iv) If your denial was based on a medical judgment of any kind, a health care professional with appropriate experience and training in the areas relevant to your claim will be consulted in making your benefit decision upon appeal. Such health care professional

will not be any individual who was previously consulted with regard to your claim or a subordinate of that individual.

(v) Identify any medical or vocational experts whose advice was obtained in connection with your claim denial, without regard to whether the advice was relied upon in making the claim denial.

(vi) If your claim involves urgent care, you will have the opportunity to use an expedited review process. You will be able to file your request for appeal via telephone, facsimile or other available similarly expeditious method.

Benefit Decisions on Appeal – Special Rules

1. Urgent Care Claims. You will be notified of the decision on your urgent care appeal as soon as possible, but no later than 72 hours after the receipt of your request for appeal.

2. Pre-Service Claims. You will be notified of the decision on your pre-service appeal within 30 days of the receipt by the Plan of your request for appeal.

3. Post-Service Claims. You will be notified of the decision on your post-service claim within 60 days of the receipt by the Plan of your request for appeal.

Manner and Content of Your Notification of Benefit Determination on Appeal

1. Any notification of benefit determination on appeal will be provided in writing or in electronic media (such as email).

2. If your claim for benefits on appeal is denied, your notice will: (i) state the specific reasons for your denial; (ii) state the specific Plan provisions on which your denial was based; (iii) include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; (iv) include a statement describing the Plan's voluntary appeals process and your right to obtain sufficient information about such procedures for you to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, and a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of your appeal; (v) if your denial was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon your request; (vi) if your denial was based on an internal rule, protocol, guideline, or other similar criterion, such internal rule, protocol, or other similar criterion will be included or a statement that you may obtain a copy of such internal rule, guideline, protocol, or other similar criterion upon your request and free of charge will be included; and (vii) a statement as to the availability of any voluntary dispute resolution mechanism.

Definitions

1. **"Urgent care claim"** means a claim for medical care with respect to which the application of large time periods for making non-urgent care determinations could seriously jeopardize your life, health or ability to regain maximum function, or in the opinion of a physician, would subject you to severe pain that could not be adequately managed without the care that is the subject of the claim.

2. **"Pre-service claim"** means any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

3. **"Post-service claim"** means any claim for a benefit under the Plan that is not a pre-service claim.

Additional Voluntary Appeal Rights

After you have exhausted your required appeal (as described above), you may also file a voluntary appeal to the Health Benefit Plan Committee. You do not, however, have to file a voluntary appeal before you can bring a civil action under Section 502(a) of ERISA, and if you bring such an action the Plan waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit the benefit dispute to this voluntary appeal procedure. Further, if you do make a voluntary appeal, the statute of limitations or other defense based on timeliness is tolled during the time that the voluntary appeal(s) is pending. A voluntary appeal will have no effect on your right to any other benefits under the Plan and no fees or costs are imposed on you as part of a voluntary appeal. Decisions on voluntary appeal will be made pursuant to the same time schedule as appeals heard by the Plan. However, if special circumstances require an extension of time for processing, you will be notified in writing. In that case, a decision will be made as soon as possible, but not later than 120 days after receiving your request for review. The manner and content of notification of benefit determination on voluntary appeal will be similar to the notification on other appeals under the Plan.

You may submit your voluntary appeal to the Health Benefit Plan Committee, c/o International Truck and Engine Corporation, P.O. Box 1097, Warrenville, IL 60555. The phone number is 1-877-353-5100 and the fax number is 1-630-753-5125. Your appeal to the Health Benefit Plan Committee must be in writing (except for urgent care appeals) and should include a Health Benefit Appeal Request Form (attached). For additional information regarding the Health Benefit Plan Committee and the voluntary appeal procedure, please refer to the Plan's Summary Plan Description.

Medical

Table of Contents

Introduction 1

Your Retiree Health Benefit Program 2
Read This Book Carefully and Put It In a Safe Place! 3
Coordinated Care 3
About This Book 3
Your Coverage is Determined by Your Medicare Eligibility 4
Foreign Service Retirees 5
U.S. Residents Not Eligible for Free Medicare Part A Coverage 5
Benefits Under Plans 1 and 2 At A Glance 6
Summary of Medical Benefits Chart 7
Summary of Prescription Drug Benefits 9
Who Is Eligible? 12
Important Questions About Eligibility 13
Eligibility for Dependents 15
Eligibility for a Surviving Spouse 17
Sponsored Dependents 18
Married to Another Navistar Employee or Retiree 19

Medical Plan 1 20

Summary 21
Summary of Benefits: What You Pay 24
About The Deductible 25
About The Copayment Maximum 25
Summary of Benefits: What Plan 1 Pays 26
Definition of Some Important Terms 31
Travel Outside the United States 31
How Plan 1 Works: Putting It All Together 31
Special Requirements For Plan 1 — 33
Precertification 33
Second Surgical Opinion 35
How Plan 1 Works Regarding Second Opinions: Putting It All Together 39
Hold Harmless Provision 40
Health Maintenance Organizations (HMOs) 43
Coordinated Care Program 43

Medical

Table of Contents

Cardiac Centers of Excellence 49
Individual Case Management 49
Home Health Care 51
Hospice 55
Covered Medical Expenses 58
These Expenses Are Not Covered by Plan 1 83
How Plan 1 Benefits Are Coordinated 87
Order of Benefit Payment 87
Administration of Coordination of Benefits 90
Subrogation 90
Right of Recovery 90
Coordination of Benefits: (Example) 91

Medical Plan 2 93
Summary 94
Summary of Benefits: What You Pay 98
What Does The Plan 2 Out-of-Pocket Maximum Include? 100
Summary of Benefits: What Plan 2 Pays 101
Medicare Part A Covered Expenses 102
Medicare Part B Covered Expenses 105
Prescription Drug Benefits 109
Definition of Some Important Terms 110
An Example of How Plan 2 Expenses Are Shared 111
Health Maintenance Organizations (HMOs) 112
Medicare-approved Expenses 112
Important Points About Plan 2 114
Covered Medical Expenses 115
Expenses Not Covered 117
How Plan 2 Benefits Are Coordinated 119
Order of Benefit Payment 120
Administration of Coordination of Benefits 122
Subrogation 122
Right of Recovery 122
How Covered Expenses Are Shared 124
Is Plan 2 Right For Me? 125

Medical

Table of Contents

Prescription Drug Plan 127

Plan 1 And Plan 2 128
The Retail Prescription Drug Plan: ValueRx 128
If You Reside In A Participating Pharmacy Area 129
A Non-Participating Pharmacy Area (If you do not reside in a ValueRx network area) 130
Covered Drugs 130
Prior Authorization Program 132
Preferred Quality Drug List (Voluntary Formulary) 132
Mandatory Generic Substitution Program 133
Express Pharmacy Mail Order Plan 133
How To Use The Mail Order Service 134
Expenses Not Covered 138
Limitations On Mail Order Plan 139

General Information 140

Right of Recovery 141
Transition Rules 142
Paying For Health Care Coverage 143
Statement of Amount Due: Front (Sample) 145
Statement of Amount Due: Back (Sample) 147
When Coverage Begins 148
Making Changes To Your Coverage 149
Pre-Existing Condition 150
When Coverage Ends 150
Filing A Claim: Steps To Follow 151
Medical Benefits Request Form 152
Medical Benefits Request Form: Front (Sample) 153
Medical Benefits Request Form: Back (Sample) 155
Explanation of Benefits (Plan 1) 156
Explanation of Medicare Benefits (Plan 2) 156
Explanation of Medicare Benefits: Part A (Sample) 157
Explanation of Medicare Benefits: Part B (Sample) 158
The Medicare Direct Program 159
Aetna Customer Relations 160

Medical

Table of Contents

Identification Cards 161
If Your Claim Is Denied 162
Health Benefit Plan Committee 163
About Medicare 164
About Medicare Part A 165
About Medicare Part B 165
Medicare Assignment and Allowable Amounts 165
Appealing a Benefit Denial 166
COBRA 167
Converting to An Individual Policy 169
Administrative Information About The Retiree Health Benefit Program Under The Navistar International Transportation Corp. Retiree Health Benefit and Life Insurance Plan 170
Funding Medium 171
Your Rights Under ERISA 171
Glossary of Important Terms Used In This Book 172
Your Rights Under ERISA 183

Introduction

Medical

Introduction

Your Retiree Health Benefit Program

This book contains a Summary Plan Description of the Navistar International Transportation Corp. Retiree Health Benefit Program negotiated as part of the settlement reached in *Shy vs. Navistar* ("Shy"), Case No. C-3-92-333 (S.D. Ohio, 1992). The Program is provided for eligible retirees, surviving spouses, and dependents of Navistar International Transportation Corp., Navistar International Corporation, Navistar Financial Corporation, Harco National Insurance Company, and Indianapolis Casting Corporation, which were formerly doing business as International Harvester Company (collectively referred to as "Navistar").

The **Shy Settlement Agreement** defines and identifies those retirees, surviving spouses and dependents who are eligible to participate in this Program. For those who are covered by "Shy," these benefits are provided for life. These benefits are also provided for life upon retirement for current active non-represented employees (and their eligible dependents) and for bargaining unit active employees (and their eligible dependents) who retire under a collective bargaining agreement that adopts the "Shy" package of retiree benefits, and for certain surviving spouses (and their eligible dependents) of active employees who die while eligible to receive a pension. This Retiree Health Benefit Program replaces all prior health benefit plans, and it may not be altered, modified or terminated except to the extent permitted under the terms of the **Shy Settlement Agreement.**

For persons hired after the effective date in non-bargaining unit positions, Navistar reserves the right to amend, modify or terminate this Program and its benefit provisions. For persons hired after the effective date in bargaining unit positions, the terms and duration of retiree benefits will be governed by collective bargaining agreements. Unless otherwise required by "Shy" or collective bargaining agreements, there is no obligation to provide these benefits or this Program to any other person.

This Retiree Health Benefit Program is effective as of the effective date of the **Shy Settlement Agreement**, or the effective date of your retirement, whichever comes later. The Program described in this book has been designed to conform to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), the United States Internal Revenue Code of 1986, and other applicable laws and regulations. The Company as named fiduciary is responsible for the administration of the Retiree Health Benefit Program, subject to the review of such administration by the Health

Medical

Introduction

Benefit Plan Committee, as provided in Articles V and VI of the **Shy Settlement Agreement**. The membership and duties of the Health Benefit Plan Committee are described on page 163 of this book. If there is a conflict between this Summary Plan Description and the Plan Document itself, the Plan Document will control.

Read This Book Carefully and Put It In a Safe Place!

Please take the time to read and understand the benefits summarized in this book. You will get the most value from your Health Benefit Program **only** if you understand how to use your benefits wisely. This book replaces any information you may have received describing benefits available under a prior plan. In the future, benefits and deductibles and copayments for this Program may change, under limited circumstances described in the **Shy Settlement Agreement**. If that is the case, you will receive a summary of any modifications to include with this Summary Plan Description.

Coordinated Care

Providing quality health care coverage at a reasonable cost is a concern of everyone. Accordingly, the Joint Navistar/UAW Committee on Health Care is in the process of developing coordinated care networks. The **Shy Settlement Agreement** permits the development of those types of plans for employees and retirees. See pages 43-48 for more information.

About This Book

This Summary Plan Description is designed to help you understand the features and benefits of your Retiree Health Benefit Program. The book is organized in **five color-coded sections** for easy reference. These sections are:

1. **Introduction,** which explains who is eligible for the Program, and how to use this book to get the information you need to use your health care benefits (Green Section),
2. **Medical Plan 1** (Blue Section),
3. **Medical Plan 2** (Red Section),
4. **Prescription Drug Plan** coverage for both medical plans, (Turquoise Section), and
5. **General Information,** which applies to both medical plans (Green Section).

Medical

Introduction

Your Coverage is Determined by Your Medicare Eligibility

Coverage is provided under two Medical plans: Plan 1 and Plan 2. The plan in which you participate is determined by your Medicare eligibility.

Plan 1 Only	Plan 2 Only
Retirees, surviving spouses, covered dependents who are: – under age 65 and NOT eligible for Medicare, **or** – age 65 or older and NOT eligible for Medicare for a reason other than age.	Retirees, surviving spouses, or covered dependents who are: – under age 65, but eligible for Medicare as their primary health insurance because of a disability or other reason, **or** – age 65 or older and eligible for Medicare as their primary health insurance. Plan 2 will supplement your Medicare coverage by helping you pay expenses that Medicare covers, but does not pay in full.

Medical

Introduction

Foreign Service Retirees

Foreign service retirees (Third Country Nationals), who repatriate (return to their home country) and are covered by National Health Care in their home country, and are under age 65, will be eligible for coverage under Plan 1 by paying the required monthly premium for Plan 1.

Foreign service retirees (Third Country Nationals), who repatriate (return to their home country) and are covered by National Health Care in their home country, and are age 65 or over, will be eligible for coverage under Plan 2 by paying the required monthly premium for Plan 2.

Foreign service retirees (Third Country Nationals) under age 65, who are not residing in the U.S., who do not repatriate and are not eligible for National Health Care in the Country in which they reside, and for whom Navistar coverage would be primary, will be eligible for coverage under Plan 1 by paying the required monthly premium for Plan 1.

Foreign service retirees (Third Country Nationals) age 65 and over, who are not residing in the U.S., who do not repatriate and are not eligible for National Health Care in the Country in which they reside, and for whom Navistar coverage would be primary, will be eligible for coverage under Plan 1 by paying the full cost of Plan 1.

U.S. Residents Not Eligible for Free Medicare Part A Coverage

Retirees and their dependents who are eligible for Medicare, but who are required to pay for Part A of Medicare because of ineligibility for Social Security Benefits or other reasons, are encouraged to enroll in Part A and pay the required Medicare Part A premium ($221 per month in 1993) since Plan 2 coverage will calculate benefits payable as if Medicare Part A coverage were in effect.

Medical

Introduction

Benefits Under Plans 1 and 2 at a Glance

Your Health Benefit Program is designed to protect you from the financial burden of a major illness or injury. The following charts provide you with an overview of how costs are shared, and summarize some of the more common expenses that Plan 1 and Plan 2 will pay.

What You Pay	Plan 1	Plan 2
Monthly Premium*	$70* per month per covered adult	$34* per month per covered adult
Annual Deductible*	$200* per covered individual	$200* per covered individual
Copayment	For most covered services, you pay 20% of the Reasonable and Customary charge. (Coordinated Care copayment explained below**)	Not applicable
Copayment Maximum*	$300* per calendar year per covered individual	Not applicable
Out-of-Pocket Maximum*	$500* per covered individual per calendar year	$200* per covered individual per calendar year
Part B Medicare Premium	Not applicable	Paid monthly by retiree/surviving spouse/dependent

* Premiums, deductibles, copayment maximums and out-of-pocket maximums may change because of increases or decreases in the cost of benefits, under limited circumstances as described in the **Shy Settlement Agreement.** Certain expenses, as listed on page 25, do not count toward the calendar year copayment maximum.

** For certain Coordinated Care benefits, there will be an **additional** copayment of 5% of the Reasonable and Customary charge based upon the benefit level reimbursement outlined in the "Coordinated Care Program" guidelines beginning on page 43.

Medical

Introduction

Summary of Medical Benefits Chart

What the Program Pays	Plan 1 Pays At This % After Annual Deductible	Plan 2 Pays At This % After Out-of-Pocket Maximum
Inpatient Hospital Expenses – Semi-private Room & Board* – Physicians' and Surgeons' Services – Laboratory & X-ray Tests – Hospice**	80%, up to your copayment maximum, then 100% Precertification is encouraged for all hospital stays; second opinions are required for certain surgeries (see pages 33-40)	100% of the difference between the Medicare-approved expense and the Medicare payment
Outpatient Medical Care – Diagnostic Laboratory & X-ray Tests – Surgery – Home Health Care** – Hospice**	80%, up to your copayment maximum per calendar year, then 100%	100% of the difference between the Medicare-approved expense and the Medicare payment
– Physician Office Visits, Other Than for Routine Care	Not Covered	100% of the difference between the Medicare-approved expense and the Medicare payment
Mental Health / Substance Abuse Care – Inpatient Psychiatric	80%, up to your copayment maximum per calendar year, then 100%; limited to 60 days per calendar year	100% of the difference between the Medicare-approved expense and the Medicare payment
– Residential Treatment for Substance Abuse	80%, up to your copayment maximum per calendar year, then 100%; limited to 35 days per calendar year	
– Outpatient (including psychiatric and or substance abuse treatment)	50%, up to your copayment maximum per calendar year, then 100%; limited to 52 visits per calendar year	

Chart continued on next page.

* and ** See explanations on page 8.

Medical

Introduction

Chart continued from previous page.

What the Program Pays	Plan 1 Pays At This % After Annual Deductible	Plan 2 Pays At This % After Out-of-Pocket Maximum
Routine Health Care		
– Pap Tests	80%, up to your copayment maximum per calendar year; then 100%	100% of the difference between the Medicare-approved expense and the Medicare payment
	Limited to 1 test per calendar year	One screening Pap test every three years
– Mammograms*** (routine screening)	100%, no deductible, subject to schedule listed and use of designated providers in certain geographic areas	100% of the difference between the Medicare-approved expense and the Medicare payment
	Ages 35-39: One for baseline **Ages 40-49**: One every two years **Age 50+**: One every year	One screening mammogram every other year if over age 65–(disabled persons under age 65 should contact Medicare regarding more frequent screenings)
– Routine Physical Exams	Not Covered	Not Covered
Other – Dental Care – Hearing Care – Vision Care	Not Covered	Not Covered

* In certain circumstances, the Program covers charges for a private room when medically necessary. Please refer to page 66 for more information.

** Home Health Care and Hospice benefits will only be available on a pre-authorized basis and benefits will be paid as outlined on pages 51-57.

*** If you live in certain geographic areas (based on ZIP code) you must use designated providers, as agreed to by the Joint Navistar/UAW Health Care Committee. See pages 67-69 for more information.

Medical

Introduction

Summary of Prescription Drug Benefits

What the Program Pays	Retirees in Plan 1 and Plan 2 Pay This Amount	Coverage Information
Prescription Drug Charges		
– ValueRx Retail Network	Generic $8 maximum/ prescription per 30-day supply Brand-name $18 maximum/prescription per 30-day supply	Copayment is per prescription per 30-day supply. 100- and 200-unit drugs that are listed on page 131 are covered in a 90-day supply with a 3-month copayment ($24 or $54)
– Express Pharmacy Mail Order Plan	$7 maximum/ prescription per 30-day supply	Copayment is per prescription per 30-day supply; maximum 90-day supply at one time For example, a 90-day supply of medication would come to $21 per prescription per covered person

Medical

Introduction

If you have any questions about your coverage, please use the following telephone numbers to call for more information.

Claims and Benefit Information Call: 1-800-435-2969 (The Navistar/ Aetna Benefits Office)

✔ When you dial this telephone number, you'll reach the Navistar/ Aetna Benefits Office. Our Customer service specialists will answer your questions about:

1. Claims,
2. Dependent eligibility,
3. Denial of benefits,
4. How benefits are coordinated with Medicare and other plans,
5. Completing the Data Collection form, or
6. Other benefits-related questions.

You can call **1-800-435-2969**, 8:00 a.m. - 5:00 p.m. (Central Standard Time), Monday-Friday.

Navistar/Aetna ID Cards Call: 1-203-636-0220

✔ Your Navistar/Aetna ID card shows which plan you are participating in, Plan 1 or Plan 2. If you need a new ID card call: **1-203-636-0220**, 8:00 a.m. - 4:00 p.m. (Eastern Standard Time), Monday-Friday.

Medicare ID Cards Call: 1-800-772-1213

✔ Your Medicare ID card identifies you as a participant in the Medicare program. This card shows the Medicare coverage you have, the date your coverage started, and your health insurance claim number. If you lose your card and need a new one call Social Security at: **1-800-772-1213**.

Precertification and Second Opinions Call: 1-800-373-1020 (Sunderbruch Corporation)

✔ Retirees and eligible dependents not covered by Medicare should notify their physicians to precertify hospital stays and certain types of care. You are required to call for a second opinion for certain procedures. Benefits will be reduced for failure to follow the guidelines of the second opinion program. (See pages 35-40 for more information.) Sunderbruch Corporation, an independent medical management and clinical review organization, has been chosen to assist with this process.

Medical

Introduction

Call Sunderbruch Corporation for questions about:

1. Precertification before a hospital stay and for certain surgical care,
2. To precertify a longer hospital stay,
3. Second surgical opinion procedures and forms,
4. Individual Case Management programs, and
5. Any situation where certification or a longer stay in the hospital has been denied.

The Precertification Program is subject to the Hold Harmless Provision described on pages 40-43. You can call **1-800-373-1020**, 24 hours a day, 7 days a week.

ValueRx
Call:
1-800-347-8777

✔ **ValueRx** handles Navistar's retail pharmacy claims. You will have separate ValueRx ID cards to use in the program. Call ValueRx for answers to questions about:

1. The name and location of a ValueRx pharmacy in your area,
2. Which drugs are covered,
3. How to submit a claim from a non-participating pharmacy,
4. Claim payments, and
5. Getting a new ID card or replacing a lost card.

You can call **1-800-347-8777**, 9:00 a.m. - 10:00 p.m., (Eastern Standard Time), Monday-Friday, 9:00 a.m. - 5:00 p.m. (Eastern Standard Time), Saturday, 10:00 a.m. - 4:00 p.m. (Eastern Standard Time), Sunday.

Express Pharmacy
Call:
1-800-222-8938

✔ **Express Pharmacy** fills prescriptions by mail order if you are participating in Plan 1 or Plan 2. Express Pharmacy will answer questions about:

1. The status of your prescription order,
2. How to get replacement order forms, and
3. When you can expect delivery of your prescription drugs.

If you have further questions, or questions that are not answered in this booklet, please contact the Human Resources Department at a company location near you. Or call the Navistar/Aetna Benefits Office at 1-800-435-2969.

Medical

Introduction

Who Is Eligible?

Retirees

You are eligible for the Navistar Retiree Health Benefit Program if you retired or will retire from Navistar with a benefit (except a deferred vested pension benefit) from one of the following plans:

- ✔ The Navistar International Transportation Corp. Retirement Plan for Salaried Employees;
- ✔ The Navistar Financial Corp. Retirement Plan for Salaried Employees;
- ✔ The Navistar International Transportation Corp. Non-Contributory Retirement Plan; or
- ✔ Certain multi-employer pension funds to which Navistar contributed.

Which Plan Do You Participate In?

There are two Plans available: Plan 1 and Plan 2. To participate in either Plan, you must meet the requirements explained above for "Retirees." Coverage under Plan 1 or Plan 2 is determined by your Medicare eligibility.

Retirees in Plan 1	Retirees in Plan 2
Under age 65 and NOT eligible for Medicare, **or** age 65 or older and NOT eligible for Medicare for a reason other than age	Under age 65 but eligible for Medicare as your primary health insurance because of a disability or other reason, **or** age 65 or older and eligible for Medicare as your primary health insurance*

* For a more complete explanation of Medicare eligibility, read *Your Medicare Handbook*. If you don't have this booklet, please call **1-800-772-1213** and request it.

Medical

Introduction

Important Questions About Eligibility

Q: What happens if Medicare changes the eligibility requirements or coverage?

A: The Program is designed to track Medicare's ongoing scope and level of benefits and its eligibility standards, as each of these features is specified under current law. An example of such a feature is the Program's coverage for the automatic increase in the Medicare Part A inpatient hospitalization deductible under current law.

Future legislation may change Medicare. If the Medicare changes are minor, the Company has the ability to change the Program accordingly, without any effect on overall benefits available from the Program. If Medicare makes major changes (such as an increase in the Medicare Part B annual deductible), the Health Benefit Plan Committee will redesign the benefits as long as the Company's liability is not increased.

Q: What about coverage for a surviving spouse or dependent?

A: If eligible, he/she will be covered under Plan 1 or Plan 2, depending on the spouse's or dependent's age and Medicare eligibility.

Q: What if I want to join an HMO instead of Plan 1 or Plan 2? Will it cost me more to do that?

A: If you currently participate, or enroll in the future, in an HMO offered by Navistar, you may continue your coverage in that plan. These plans generally offer medical and prescription drug coverage, and some offer vision and hearing care services. To the extent that the HMO does not provide drug benefits substantially equivalent to the Company policy, arrangements will be made to provide those benefits through the Company Program. HMO coverage also offers physician's office visits and preventive care.

Navistar will pay the premium for the Health Maintenance Organization (HMO) coverage up to the cost the Company would have incurred if the retiree or surviving spouse were covered by the Company Program. HMO premiums in excess of the cost of the Company Program are the responsibility of the retiree or surviving spouse.

Q: What happens if I decide not to participate in Plan 1 or Plan 2 when I am first eligible or if I allow my coverage to lapse?

A: ✔ If you or your spouse has other employment-based coverage which terminates for any reason, you can enroll in Plan 1 or

Introduction

Plan 2 within **60 days** of your loss of coverage without penalty. You must submit documentation concerning the loss of coverage.

- ✔ If you have elected COBRA coverage and your COBRA rights expire, or if you elect not to continue your COBRA coverage, you may re-enroll in the Plan within **60 days** of the termination of your COBRA coverage, without penalty.
- ✔ If you choose to enroll in Plan 1 or Plan 2 after **60 days** of the loss of your employment-based or COBRA coverage, you can do so, but you will be subject to a **12-month** pre-existing condition provision. See page 150 for an explanation of the pre-existing condition provision.
- ✔ If your coverage under Plan 1 or Plan 2 lapses because you have not paid the premium within the **45-day** grace period, you can re-enroll in either Plan 1 or Plan 2, but a **12-month** pre-existing condition provision applies. See page 150 for a description of the pre-existing condition provision.
- ✔ If you have other individual or group coverage and it terminates for any reason, you can enroll in Plan 1 or Plan 2 within **60 days** of your loss of coverage, without penalty, as long as the premium paid for the previous coverage is equal to or greater than the applicable 1993 Plan 1 or Plan 2 retiree-paid premium **or** the future applicable Plan 1 or Plan 2 retiree-paid premium, whichever is more. You must submit documentation concerning the loss of coverage and the amount of premium.
- ✔ If you do not enroll in Plan 1 initially, or in Plan 2 at age 65, and have no other coverage, you may enroll at any time, but you will be subject to a **12-month** pre-existing condition provision. See page 150 for a description of the pre-existing condition provision.
- ✔ If you receive health care coverage from a public plan (such as Medicaid, State Workers' Compensation or Veterans' programs) and lose eligibility for this coverage for any reason, you may enroll in Plan 1 or Plan 2 at any time, without penalty.

If you choose not to enroll in Plan 1, you may still enroll in Plan 2 when you reach age 65 or become eligible for Medicare, without penalty.

Medical

Introduction

Eligibility for Dependents

Eligible dependents are:

- ✔ Your husband or wife,
- ✔ Your unmarried children residing in your household, or
- ✔ Your unmarried children for whom you are legally required to provide medical care.

Spouse means the person to whom you are legally married. It does not include a former spouse from whom you are divorced.

If a retiree has retiree coverage only and thereafter marries or otherwise acquires a dependent or an additional dependent, coverage for such dependent will become effective on the date the retiree acquires the dependent. In the event that the retiree fails to notify the Company of such dependent before a claim is incurred, no benefit will be paid until satisfactory evidence is submitted establishing that the dependent was acquired prior to the date the claim was first incurred.

Children include:

- ✔ natural born children,
- ✔ legally adopted children,
- ✔ step-children for whom legal adoption proceedings have been initiated, and
- ✔ children dependent on the retiree for more than one-half of their support, as defined by the Internal Revenue Code of the United States of America, who either qualify in the current year for dependency status, or who have been reported as dependents on the retiree or surviving spouse's most recent federal income tax return. The child must **legally reside** with the Retiree or Surviving Spouse and either be related by blood or marriage, or be under the Retiree or Surviving Spouse's legal guardianship.

Children will be covered until the end of the calendar year in which they reach age 19.

1. **Coverage will be extended up to the end of the calendar year in which a child reaches age 25,** if they meet the following requirements. Your child:
   - ✔ Is unmarried, and
   - ✔ Legally resides in your household or, if not a resident, is a child for whom you are legally required to provide health care, and

Introduction

✔ Either qualifies in the current year for dependency tax status, or has been reported as a dependent on the Retiree or Surviving Spouse's most recent federal income tax return.

> Note:
> **A child will be considered as legally residing in the Retiree or Surviving Spouse's household** if he/she is in full-time attendance at an educational institution. The dependent child will not be deprived of coverage merely because he/she has obtained legal residency for voting or tuition purposes in the state where he/she is attending school.

2. **If your covered child is totally and permanently disabled** at the time the child's coverage would otherwise terminate, coverage will be continued for as long as the child remains totally and permanently disabled, as approved by Navistar. The company will provide a special form to the disabled person to be completed by the treating physician. The form requests pertinent information necessary to establish total and permanent disability status. The Health Benefit Plan Committee will resolve eligibility disputes.

Dependents may participate in Plan 1 or Plan 2 depending on their Medicare eligibility.

Dependents Participating In Plan 1	**Dependents Participating In Plan 2**
Under age 65 and NOT eligible for Medicare, **or** age 65 or older and NOT eligible for Medicare for a reason other than age	Under age 65 but eligible for Medicare as their primary health insurance because of a disability or other reason, **or** age 65 or older and eligible for Medicare as their primary health insurance

For example, if a covered dependent is age 60 and NOT eligible for Medicare, but the covered retiree is age 65 and eligible for Medicare, the dependent would be enrolled in Plan 1, and the retiree would be enrolled in Plan 2.

Medical

Introduction

Note:
- ✔ Coverage is NOT available to:
  - dependents who are in military service or the Peace Corps (or similar service) of any country, or
  - dependents covered under any other health care plan sponsored by Navistar.

For a more complete explanation of Medicare eligibility, read *Your Medicare Handbook*. If you don't have this booklet, please call **1-800-772-1213** and request it.

Eligibility for a Surviving Spouse

A Surviving Spouse is eligible for the Navistar Retiree Health Benefit Program if he/she is:

- ✔ The Surviving Spouse of a Retiree who participated in one of the previously mentioned retirement plans;
- ✔ The Surviving Spouse of an active employee who died after becoming eligible for normal or early retirement under either **(a)** the Navistar Corp. Retirement Plan for Salaried Employees or **(b)** the Navistar Financial Corp. Retirement Plan for Salaried Employees; **or**
- ✔ The Surviving Spouse of an employee who died after becoming eligible for normal or regular early retirement under the Navistar International Transportation Corp. Non-Contributory Retirement Plan.

Note:
If the retiree waived Navistar coverage because he/she was employed and had coverage elsewhere, the surviving spouse would have the opportunity to enroll in the Navistar Program within 60 days of the loss of coverage.

Medical

Introduction

The Surviving Spouse may participate in Plan 1 or Plan 2 based on his/her Medicare eligibility.

Plan 1	Plan 2
under age 65 and NOT eligible for Medicare, **or** age 65 or older and NOT eligible for Medicare for a reason other than age	under age 65 but eligible for Medicare as his/her primary health insurance because of a disability or other reason, **or** age 65 or older and eligible for Medicare as his/her primary health insurance*

* For a more complete explanation of Medicare eligibility, read *Your Medicare Handbook.* If you don't have this booklet, please call **1-800-772-1213** and request it.

Sponsored Dependents

If you have relatives or residents of your household who do not qualify as regular dependents, but are dependent on you for more than one-half of their support as defined by the Internal Revenue Service Code, they may be eligible for coverage as sponsored dependents.

"Sponsored Dependent" means any person not included in the term "dependent" who:

- ✔ is related to the retiree/surviving spouse by blood or marriage, or
- ✔ is a resident member of the retiree/surviving spouse's household, and
- ✔ is dependent upon the retiree/surviving spouse for more than one-half of his/her support, as defined by the Internal Revenue Code of the United States, and either qualifies in the current year for dependency tax status, or has been reported by the retiree/surviving spouse as a dependent on his/her most recent Federal income tax return.

Medical

Introduction

Excluded from the definition of "sponsored dependent" is:

- ✔ any person who is otherwise covered either as an employee or dependent under any similar hospital/surgical/medical coverage to which the Company contributes,
- ✔ any person in the military or similar forces of any country, or of any subdivision of a country, and
- ✔ any person in the Peace Corps or similar service of any country or subdivision of a country.

Whether a Sponsored Dependent is covered under Plan 1 or Plan 2 will depend on his or her age and eligibility for Medicare. Sponsored Dependents are subject to the same **individual** deductibles and copayments that apply to retirees and surviving spouses. Applicable monthly premiums will be deducted from your pension check. If your net pension benefit is not enough to cover the monthly premium, you will be required to pay the premium by personal check. The premium will be the full cost of the Plan.

As of the effective date of this Program, the cost was set at $249 per month for each sponsored dependent not eligible for Medicare (Plan 1), and $78 per month for each sponsored dependent eligible and enrolled in Medicare Part A and Medicare Part B (Plan 2). The amount of contribution may change from time to time as determined by the Company.

You may add Sponsored Dependents to your coverage as long as you enroll them within **31 days** after they become eligible for coverage and you pay the full premium cost; otherwise, you may enroll Sponsored Dependents during the annual enrollment period designated by the Company. The open enrollment is normally during the month of December.

Married to Another Navistar Employee or Retiree

If you are married to another Navistar employee or retiree, you may elect to:

- ✔ Be covered as a dependent of your spouse, or
- ✔ To maintain your own coverage.

Your eligible children may be covered under either Plan, but not under both Plans.

Medical Plan 1

Medical

Medical Plan 1

Summary

What Plan 1 Pays	Plan 1 Pays At This % After Annual Deductible
Inpatient Hospital Expenses – Semi-private Room & Board* – Physicians' and Surgeons' Services – Laboratory & X-ray Tests – Hospice**	80%, up to your copayment maximum, then 100%. Precertification is encouraged for all hospital stays. Second opinions are required for certain surgeries (see pages 33–40)
Outpatient Medical Care – Diagnostic Laboratory & X-ray Tests – Surgery – Home Health Care** – Hospice**	80%, up to your copayment maximum, then 100%
– Physician Office Visits	Not Covered
Mental Health/ Substance Abuse Care – Inpatient Psychiatric	80%, up to your copayment maximum per calendar year, then 100%; limited to 60 days per calendar year
– Residential Treatment for Substance Abuse	80%, up to your copayment maximum per calendar year, then 100%; limited to 35 days per calendar year
– Outpatient (including psychiatric and/or substance abuse treatment)	50%, up to your copayment maximum per calendar year, then 100%; limited to 52 visits per calendar year

Chart continued on next page.

* and ** See explanations on page 22.

Medical

Medical Plan 1

Chart continued from previous page.

What Plan 1 Pays	Plan 1 Pays At This % After Annual Deductible
Routine Health Care	
– Pap tests	80%, up to copayment maximum, per calendar year, then 100%. Limited to 1 test per calendar year
– Mammograms*** (routine screening)	100%, no deductible, subject to schedule listed and use of designated providers in certain geographic areas **Ages 35 - 39:** One for baseline **Ages 40 - 49:** One every two years **Ages 50+:** One every year
– Routine Physical Exams	Not Covered
Other	
– Dental Care – Hearing Care – Vision Care	Not Covered

* In certain circumstances, the Program covers charges for a private room when medically necessary. Please refer to page 66 for more information.

** Home Health Care and Hospice benefits will only be available on a pre-authorized basis and benefits will be paid as outlined on pages 51-57.

*** If you live in certain geographic areas (based on ZIP code) you must use designated providers, as agreed to by the Joint Navistar/UAW Health Care Committee. See pages 67-69 for more information.

Chart continued on next page.

Medical Plan 1

Chart continued from previous page.

What Plan 1 Pays	Retirees in Plan 1 Pay This Amount	Coverage Information
Prescription Drug Charges		
– ValueRx Retail Network	Generic $8 maximum/ prescription per 30-day supply Brand-name $18 maximum/prescription per 30-day supply	Copayment is per prescription per 30-day supply. 100- and 200-unit drugs that are listed on page 131 are covered in a 90-day supply with a 3-month copayment ($24 or $54)
– Express Pharmacy Mail Order Plan	$7 maximum/prescription for 30-day supply	Copayment is per prescription per 30-day supply; maximum 90-day supply at one time For example, a 90-day supply of medication would come to $21 per prescription per covered person

Medical

Medical Plan 1

Medical Plan 1 is designed to help protect you from the financial problems that can accompany a serious disease or injury. You and Navistar share in the costs of providing this coverage using a combination of shared premiums and shared medical expenses. This chart provides an overview of what you pay toward benefits.

Summary of Benefits: What You Pay

What You Pay	How Much You Pay
Monthly Premiums** The amount you pay each month for yourself and each covered adult to participate in Medical Plan 1	$70** per month per covered adult
Annual Deductible** The amount each individual must pay toward medical expenses each calendar year before Plan 1 begins paying benefits	$200** per covered individual per calendar year
Copayment The percentage of the Reasonable and Customary charge for covered services shared by you (20%) and Navistar (80%), after you meet an annual deductible. (Coordinated Care copayment explained below)*	For most covered services, you pay 20% of the Reasonable and Customary charge and Navistar pays 80% of that charge.
Copayment Maximum** The most each covered individual will pay toward covered medical expenses (after the deductible) each calendar year, except for the copayment exclusions listed on page 25. Once your share of covered expenses exceeds the copayment maximum, Plan 1 will pay 100% of covered medical expenses for the rest of that calendar year.	$300** per covered individual per calendar year

* For certain Coordinated Care benefits there will be an additional copayment of 5% of the Reasonable and Customary charge based upon the benefit level reimbursement outlined in the "Coordinated Care Program" guidelines beginning on page 43.

** Periodically, premiums, deductibles, and copayment maximums may change because of increases or decreases in the cost of benefits, under limited circumstances described in the Shy Settlement Agreement.

Medical

Medical Plan 1

About The Deductible

There are 3 important points to remember about the deductible:

1. You must pay your covered medical expenses up to the deductible amount each calendar year before benefits begin. A calendar year starts on January 1 and ends on December 31.
2. The deductible applies separately to each covered individual under Plan 1.
3. The deductible may change each year because of changes in the cost of benefits.

About The Copayment Maximum

The following types of expenses will not count toward the annual copayment maximum:

1. Individual calendar year deductibles.
2. Drug copayments.
3. Penalties for failing to get a second opinion when required.
4. All premiums are above and beyond out-of-pocket maximums.

The copayment maximum may increase each year because of increases in the cost of benefits.

Medical

Medical Plan 1

Summary of Benefits: What Plan 1 Pays

Plan 1 covers only services and supplies that are considered medically necessary. Payment is limited to the Reasonable and Customary (R&C) charge for providing a service or supply. Charges that are not medically necessary or charges that are above reasonable and customary fall under provisions of the Hold Harmless language defined on pages 40-43. The following chart summarizes some of the more common expenses that Plan 1 pays, based upon reasonable and customary guidelines. For a more complete listing, turn to "Plan 1 Covered Medical Expenses" beginning on page 58 of this book.

Plan 1 Pays These Expenses	At This % After Annual Deductible	Coverage Information
Inpatient Hospital Expenses		
– Semi-private room and miscellaneous expenses*	80%, up to your copayment maximum, then 100%	Precertification of all hospital stays is encouraged
– Physicians' and surgeons' fees and supplies	80%, up to your copayment maximum, then 100%	Second opinion for certain surgeries is required (see pages 35-40 for more information)
– Laboratory & X-ray tests	80%, up to your copayment maximum, then 100%	
– Hospice**	80%, up to your copayment maximum, then 100%	See pages 55-57 for more information

* In certain circumstances, the Program covers charges for a private room when medically necessary. Please refer to page 66 for more information.

** Home Health Care and Hospice benefits will only be available on a pre-authorized basis and benefits will be paid as outlined on pages 51-57.

Chart continued on next page.

Medical

Medical Plan 1

Chart continued from previous page.

Plan 1 Pays These Expenses	At This % After Annual Deductible	Coverage Information
Outpatient Medical Care		
– Diagnostic laboratory and X-ray tests	80%, up to your copayment maximum, then 100%	
– Surgery, including the surgeon, assistant surgeon, and anesthesiologist	80%, up to your copayment maximum, then 100%	Second opinion for certain surgeries required (see pages 35-40 for more information)
– Home Health Care**	80%, up to your copayment maximum, then 100%	See pages 51-54 for more information
– Hospice**	80%, up to your copayment maximum, then 100%	See pages 55-57 for more information
– Physician Office Visits	Not Covered	
Emergency Care	80%, up to your copayment maximum, then 100%	Emergency medical care for injuries and serious acute medical conditions (see page 65 for more information)

** Home Health Care and Hospice benefits will only be available on a pre-authorized basis and benefits will be paid as outlined on pages 51-57.

Chart continued on next page.

Medical

Medical Plan 1

Chart continued from previous page.

Plan 1 Pays These Expenses	At This % After Annual Deductible	Coverage Information
Convalescent Facility Confinement	80%, to a limit of 730 days per benefit period, up to your copayment maximum, then 100% For psychiatric stays, 80%, subject to certain limits, then 100%	Psychiatric stay must immediately follow a hospital stay. Limit of 90 days per calendar year for psychiatric stays
Private Nursing	80%, up to copayment maximum, then 100%	
Mental Health/ Substance Abuse Care		
– Inpatient Psychiatric	80%, up to your co-payment maximum per calendar year, then 100%; subject to certain limits	Limited to 60 days per calendar year
– Residential treatment for substance abuse	80%, up to your co-payment maximum per calendar year, then 100%; subject to certain limits	Limited to 35 days per calendar year
– Outpatient (including psychiatric and/ or substance abuse treatment)	50%, up to your co-payment maximum per calendar year, then 100%; limited to 52 visits per calendar year	Pays toward 52 visits per calendar year

Chart continued on next page.

Medical Plan 1

Chart continued from previous page.

Plan 1 Pays These Expenses	At This % After Annual Deductible	Coverage Information
Routine Health Care		
– Pap tests	80%, up to copayment maximum, then 100%	Limited to 1 test per calendar year
– Mammograms*** (routine screening)	100%, no deductible, subject to schedule listed and use of designated providers in certain geographic areas	**Age 35-39:** One for baseline **Age 40-49:** One every two years **Age 50+** One every year See "Mammogram, Routine," in the "Covered Expenses" section beginning on page 58 for details on payment and designated providers
– Routine physical exams	Not Covered	

*** If you live in certain geographic areas (based on ZIP code); you must use designated providers as agreed to by the Joint Navistar/UAW Health Care Committee. See pages 67-69 for more information.

Chart continued on next page.

Medical

Medical Plan 1

Chart continued from previous page.

What the Program Pays	Retirees in Plan 1 Pay This Amount	Coverage Information
Prescription Drug Charges		
– ValueRx Retail Network	Generic $8 maximum/ prescription per 30-day supply Brand name $18 maximum/ prescription per 30-day supply	Copayment is per prescription per 30-day supply. 100- and 200-unit drugs listed on page 131 are covered in a 90-day supply with a 3-month copayment ($24 or $54)
– Express Pharmacy Mail Order Plan	$7 maximum/ prescription per 30-day supply	Copayment is per prescription per 30-day supply; maximum 90-day supply at one time For example, a 90-day supply of medication would come to $21 per prescription per covered person

Medical

Medical Plan 1

Definition of Some Important Terms

- ✔ **Covered Expense:** Any necessary, reasonable and customary item of expense for service covered in whole or in part under this Program, or any other plan in which the individual covered under this Program is enrolled. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed to be a benefit paid.
- ✔ **Medically Necessary:** A service or supply that is necessary for the diagnosis, care or treatment of the physical or mental condition involved. Refer to the "Glossary" for a complete definition.
- ✔ **Reasonable and Customary Charge:** The lower of the provider's usual charge for furnishing a service, and the charge Aetna determines to be the prevailing charge in the geographic area where it is furnished. Plan 1 covers only the part of a medical expense that is considered reasonable and customary. Refer to the "Glossary" for a complete definition.

Travel Outside the United States

Benefits are payable under the provisions of Plan 1 for any claim incurred outside the continental limits of the United States of America, Hawaii, Alaska, and the provinces of the Dominion of Canada if such claim is incurred during a temporary absence of less than 6 months from such geographical area.

How Plan 1 Works: Putting It All Together

Sue Jones, a Navistar retiree, is covered under Medical Plan 1. In June of this calendar year, Sue had medical and hospital expenses of $2,000. The services were medically necessary and fell within reasonable and customary guidelines. Here are the steps to follow in determining the amount of benefits payable by Plan 1.

Medical

Medical Plan 1

Here's what happened to Sue:		Sue
What is the total amount of covered expense for this illness?	1.	$ 2,000
Has Sue met the annual deductible? If not, that amount is subtracted first from the covered expenses.	2.	− 200
The remaining amount is the eligible expense covered by Plan 1.		$ 1,800
How much of the remaining expense will Plan 1 Pay? Usually 80% of the eligible expense.	3.	$ 1,800 x 80 % $ 1,440
How much of the remaining charge will Sue have to pay? Sue's copayment amount is usually 20%. However, she is only responsible for the annual copayment maximum of $300, so Plan 1 will pay the additional $60.	4.	$ 1,800 x 20 % $ 360
To summarize, here's what Sue and Plan 1 paid for these expenses.	5. Sue:	$ 300 (copayment) + 200 (deductible) $ 500 Total
	6. Plan 1:	$ 1440 (80% share) + 60 Amount exceeding Sue's copayment maximum $ 1500 Total

Medical

Medical Plan 1

Special Requirements For Plan 1 — Precertification

Medical studies have consistently shown that a significant percentage of hospitalizations and medical procedures are unnecessary. Unnecessary or extended confinements and procedures can affect the quality of care for patients and result in excessive costs.

The goal of precertification is to help ensure the treatment you receive as a hospital inpatient and the length of your hospital stay are medically necessary and appropriate for your illness, while minimizing cost to the Company. The Precertification program does not apply to HMO members or to individuals covered by Medicare, since these plans have their own programs for reviewing medical necessity.

The Precertification program is administered by Sunderbruch Corporation. It is used to help ensure that the treatment you receive as a hospital inpatient and the length of your hospital stay are appropriate for your illness. **The Precertification program does not apply to individuals covered by Medicare. Medicare has its own programs for reviewing medical necessity.**

What To Precertify

You should instruct your physician to precertify hospital stays. If your physician fails to precertify your hospitalization, you are encouraged to call Sunderbruch directly.

When To Precertify

- ✔ **Non-emergency admissions:** May be certified at least **7 days**, but not more than **14 days in advance.**
- ✔ **Emergency admissions:** May be certified no later than **48 hours** after the start of an admission, or within the first business day following admission on a weekend or holiday.
- ✔ **Maternity admissions:** May be certified at least **14 days**, but not more than **60 days**, in advance of the expected delivery date.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

How To Precertify

If your physician recommends a hospital admission, follow these steps.

1. **Have your physician call Sunderbruch at 1-800-373-1020.** Sunderbruch's Hotline is available 24 hours a day, 7 days a week. It is always staffed by professional nurses.
2. **Have the physician describe your case to the Sunderbruch nurse.**
   - ✔ **If your hospital stay can be certified,** the nurse will do so after discussion with your physician.
   - ✔ **If your hospital stay cannot be certified,** a physician advisor will review your case. He or she may also discuss it with your physician. Determination for certification or non-certification of your stay will be based upon the physician review. Please see pages 40-43 regarding the Hold Harmless Provision as it applies to hospital stays deemed to be not medically necessary.

Important: Ask your physician to call the Sunderbruch number, or you may do so yourself. If you make the call to Sunderbruch yourself, please be prepared to give the nurse the following information:

- ✔ The patient's name and insured's Social Security number.
- ✔ The physician's name and telephone number.
- ✔ The anticipated hospital admission date.
- ✔ The name and location of the hospital.

Note:
If precertification is requested and denied, no benefits are payable for hospital room and board charges, inpatient physician charges, or other charges for services not medically necessary. These charges fall under the Hold Harmless Provision of the Program, which is described on pages 40-43.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical Plan 1

Other Services

During your hospital stay, Sunderbruch also offers the following services:

- ✔ **Continued Stay Review.** Your Sunderbruch team will follow your case and talk with your physician, if needed, to determine the necessity of continuing hospital care.
- ✔ **Discharge Planning.** If you need additional care after your hospitalization, such as nursing home care, your Sunderbruch team will work with your physician to help arrange for these services through the Individual Case Management Program (ICM).

The Joint Navistar/UAW Committee on Health Care is responsible for selecting the precertification administrator and for monitoring the program, including the concurrent on-site review process. The administrator will be instructed not to visit the patient during his or her hospitalization when conducting concurrent on-site reviews. If there are problems that arise in this process, it is the responsibility of this committee to resolve them. If the Joint Committee ceases to exist, or fails to act, these responsibilities will be transferred to the Health Benefit Plan Committee.

Second Surgical Opinion

Second surgical opinion is a way to determine whether surgery is necessary and the most effective treatment for your condition. It gives you the benefit of another qualified opinion when your doctor recommends certain surgeries.

Which Procedures Need A Second Opinion Review?

A second surgical opinion review is required for the following elective, non-emergency procedures. To receive the maximum benefit payable by Plan 1, you must initiate the second opinion review process for the surgical procedures on this Checklist.

- ✔ **Bunionectomy**...surgical removal of bunions.
- ✔ **Carotid Endarterectomy**...surgical incision into carotid artery.
- ✔ **Carpal Tunnel Release**...surgery of wrist nerve/tendon.
- ✔ **Cataract Extraction**...surgical removal of cataracts and/or ultrasound of the eye.
- ✔ **Cholecystectomy**...surgical removal of the gall bladder.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

- ✔ **Coronary Angiography**...X-ray visualization of heart arteries and/or chambers by insertion of catheter through vein into heart.
- ✔ **Coronary Artery Bypass Surgery**...surgical "detour" of circulation in heart arteries.
- ✔ **Dilation and Curettage (D&C)**...examination of cervix and removal of tissue from the lining of the uterus for examination.
- ✔ **Hemorrhoidectomy**...surgical removal of rectal varicose veins.
- ✔ **Hernia Repair**...repair of inguinal hernia.
- ✔ **Hysterectomy**...surgical removal of uterus.
- ✔ **Knee Surgery**...surgery of knee.
- ✔ **Laminectomy**...surgical removal of bone from the spine.
- ✔ **Mastectomy**...surgical removal of the breast(s).
- ✔ **Myringotomy with Insertion of Drainage Tubes**...surgical incision into ear drum and insertion of drainage tubes.
- ✔ **Prostatectomy**...surgical removal of part or all of prostate.
- ✔ **Septoplasty**...nose surgery.
- ✔ **Spinal Fusion**...fusion of spinal column.
- ✔ **Strabismus Repair**...surgical correction of eye muscle coordination.
- ✔ **Temporomandibular Joint**...jaw joint disorder.
- ✔ **Thyroidectomy**...surgical removal of the thyroid gland.
- ✔ **Tonsillectomy/Adenoidectomy**...surgical removal of tonsils/adenoids.
- ✔ **Transurethral Prostate Dilitation (TUPD)**...stretching of the prostate to remove urinary blockage.
- ✔ **Varicose Vein Ligation and/or Stripping**...repair of varicose veins in leg.

When To Request A Second Opinion Review

- ✔ Non-emergency procedures: At least **7 days before** the scheduled date of the procedure.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

Steps to Follow for Getting a Second Opinion Review

When your physician recommends surgery for one of the listed procedures, follow these steps.

1. **Call Sunderbruch at 1-800-373-1020.**
   Sunderbruch's Hotline is available 24 hours a day, 7 days a week. It is always staffed by professional nurses.
2. **Describe your case to the Sunderbruch nurse.**
   The nurse will consult with your physician and will certify your surgery, if appropriate.
   - ✔ **If your surgery can be certified,** that decision will be valid for 60 days.
   - ✔ **If your surgery cannot be certified,** a physician advisor will review your case and will also discuss it with your physician. Alternative care may be suggested. **You and your physician will decide whether or not to pursue the suggested alternative care. If the alternative care is not normally a covered benefit, it will be covered on an exception basis.** Or you may be required to get a second surgical opinion and to visit a Second Opinion Center once they are established. Sunderbruch will contact you if you need to obtain a second opinion.

If you don't get a second opinion when required, your benefits will be reduced!

3. **Find out if your surgery requires a second surgical opinion.** Review the listing in this section of the booklet, and discuss your surgery with the Sunderbruch nurse.
   - ✔ **If you are having a surgery that requires a second opinion and your surgery is certified,** the second opinion requirement will be waived.You will receive the waiver in writing.
   - ✔ **If you are having a surgery that requires a second opinion and are told by Sunderbruch to obtain a second opinion,** you must get the second opinion or your benefits will be reduced. The charge for the second opinion will be paid at 100%, and will not be subject to your annual deductible or copayment. In cases where a room or facility charge is associated with obtaining a second opinion, the room or facility charge will be paid. Begin the second surgical opinion process at least **seven (7) days** before a scheduled procedure. You will need to obtain a second opinion form from Sunderbruch.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

Note:
In some cases, the need for a second opinion for one of the listed procedures will be waived by Sunderbruch. You may choose to get a second opinion or third opinion anyway for your own peace of mind. If you do, they will be covered at 100% if you follow the second opinion process through Sunderbruch. You will need to call Sunderbruch to get a second opinion form.

Remember, you always retain the right to choose surgery or to explore alternative care after you have gone through the second opinion review process.

The Joint Navistar/UAW Committee on Health Care is responsible for choosing the second opinion administrator and monitoring the program. These responsibilities will be deferred to the Health Benefit Plan Committee if the Joint Committee ceases to exist or fails to act.

Note:
If you or a covered dependent does not follow the second surgical opinion process, your medical benefits will be reduced. If you fail to call Sunderbruch about a surgery that requires a second surgical opinion, benefits paid for your surgeon's charges will be reduced by 20%. The maximum penalty reduction is **$300**. This penalty is in addition to any deductible or copayment expenses.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

How Plan 1 Works Regarding Second Opinions: Putting It All Together

Here's What Happened to Dan:

Dan called Sunderbruch to precertify his planned knee surgery. Sunderbruch required a second opinion before certifying the procedure. At the time of the surgery, Dan had met his annual $200 deductible. But he still has to meet his $300 copayment maximum.

Assuming the surgery was medically necessary and the charges fell within reasonable and customary guidelines, here's what would happen if Dan obtained a second opinion—and if he didn't!

Eligible Expenses:

✔ Hospital Charges	$1000
✔ Surgeon's Charges	500
✔ Second Opinion	+ 100
✔ Total Charges:	$1600

If Dan Had A Second Opinion		**If Dan Did Not Have A Second Opinion**	
Plan 1 Expenses Covered at 80%		**Plan 1 Expenses Covered at 80%**	
Hospital	$ 1,000	Hospital	$ 1,000
Surgeon	+ 500		x 80 %
Total Eligible Charges	$ 1,500	Paid by Plan 1	$ 800
Plan 1 usually shares 80%	x 80 %	Surgeon's Charge	$ 500
		Penalty for not getting second opinion	x 20 %
			$ 100
		Subtract 20% penalty from surgeon's charge	$ 500
			- 100
			$ 400
		Plan 1 copayment	x 80 %
Plan 1 Payment	$ 1,200		$ 320
		Total Hospital and Surgeon's Fee paid by Plan 1	$ 800
			+ 320
			$ 1,120

Example continued on next page.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

Example continued from previous page.

If Dan Had A Second Opinion		If Dan Did Not Have A Second Opinion	
Plan 1 Expenses Covered at 100%		**Plan 1 Expenses Covered at 100%**	
Second Opinion Fee	$ 100	Second Opinion Fee	$ 0
	x 100 %		
Plan 1 Payment	$ 100	Dan failed to get the Second Opinion required	
Total Paid by Plan 1	$ 1,200	Total Paid by Plan 1	$ 1,120
	+100		
	$ 1,300		
Total Paid by Dan	$ 300	Total Paid by Dan	$ 380
Since Dan has now met his annual copayment maximum, any further covered expenses will be paid by Plan 1 at 100% for the rest of the calendar year.		In this case, Dan has to pay a copayment of $280 plus the penalty charge of $100 for failing to get a Second Opinion. Remember, penalties do not count toward the annual copayment maximum.	

Hold Harmless Provision

Navistar has for many years included a Hold Harmless Provision under its health care coverage. Its purpose is to provide necessary assistance when a provider, such as a physician or other provider, charges more than the reasonable and customary amount allowed by the Program or when services performed were not medically necessary as determined by the Program. Under this Provision, you are provided with legal assistance to defend against these excessive charges. Navistar or the Insurance Company will take every reasonable action to resolve such disputes without residual payment by you.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical Plan 1

The provision does not apply if you have agreed to or ratified the charge, or for services and supplies not covered under the Program. However, if you sign a standard form required by the health care provider for purposes of admission and/or services to be delivered, and the form states that "you agree to pay all charges," this will not be considered in any way as an agreement that you will pay medically unnecessary or excess charges. In addition, the Hold Harmless Provision does not apply to any supplies or services that you requested and that you knew were not medically necessary; for example, if your physician wants to release you from the hospital at 3:00 p.m. on Thursday, but because it is more convenient for you, you stay until Friday.

In the event it is determined that any medical services or day or days of confinement are not necessary, the Company or Insurance Company will take every reasonable action to resolve the charges for the unnecessary services, or day or days of confinement, so that there is no residual payment due by the retiree or dependent for such services, or any day of confinement, determined to be unnecessary by the review committee or medical foundation. The provisions of this paragraph will apply if it is established that the retiree or dependent neither agreed to nor ratified the charges for days of confinement or services determined to be unnecessary.

It is the intention of the Company to support the retiree on any claim by a provider for charges incurred after a notice of determination by a utilization review body that the admission, services, duration of hospital stay or other procedures are not medically necessary or appropriate. The Company's support shall include all costs connected with the claim. In the event that legal action is brought by the hospital or nursing home or any other facility for such charges, the Company or the Insurance Company will undertake to provide the defense of such action, will pay the expenses of providing such defense, and will pay any resulting judgment entered against the retiree or dependent. It is understood that in order to be relieved of any obligation for any amount of such charges, the person involved in such action will be obligated to testify, submit to examination, release information and furnish any evidence in his possession upon request.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

As noted above, if charges are denied because they are not medically necessary or exceed the reasonable and customary charge allowable, one of two things will happen:

1. The provider will accept Aetna's reimbursement as payment in full, **or**
2. The provider will bill you for the balance due.

If the provider bills you for the balance due, you will have **two options:**

1. Pay the additional amount due, **or**
2. Send copies of the balance due bill and Aetna's Explanation of Benefits (EOB) along with a signed statement that you wish to be held harmless to **Customer Relations, Aetna Life and Casualty, P.O. Box 7011, Rockford, IL 61125.** After receiving your letter, Customer Relations will write to the provider and ask for additional information or if the provider will accept Aetna's fees. No further action should be taken unless you receive another balance due bill.

   If you continue to withhold payment of the balance due, you may receive additional notices from your provider and possibly from a collection agency. **Navistar or the Insurance Company will communicate its full legal support of you to the health care provider, and will use its best efforts to prevent the health care provider or its representatives from taking any action that adversely affects your credit record relating to these disputed charges.** Aetna cannot stop the provider or collection agency from sending additional notices.

   If you get a notice from a collection agency, forward it to Aetna/Customer Relations, and they will send a letter to the agency telling them why the bill hasn't been paid. Navistar cannot guarantee that the letter sent by Aetna will prevent your credit rating from being affected.

No further action can be taken by Navistar or Aetna until the provider files suit against you for payment. If you receive notice of a suit, call Aetna Customer Relations at **1-800-435-2969** to advise them of this. Aetna will provide legal counsel to defend the suit and pay all expenses associated with it (i.e. judgment, court costs and legal fees). As you are the named defendant in this suit, you will be expected to attend the hearing and possibly testify. Aetna or other resources will also be testifying in your defense.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

You also need to be aware of the fact that this process may take several months to be resolved.

Although the Hold Harmless Provision is a service Navistar provides, your full support is necessary for the Hold Harmless Provision to work.

Important!
If you make payment in full or in part to a provider for services or supplies that were denied because of R&C or medical necessity, the Hold Harmless Provision will not apply.

The Health Benefit Plan Committee is responsible to monitor the Hold Harmless Provision and will resolve disputes arising from it.

Health Maintenance Organizations (HMOs)

These plans generally offer medical and prescription drug coverage, and some offer vision care and hearing care services. To the extent that the HMO does not provide drug benefits substantially equivalent to the Company policy, arrangements will be made to provide those benefits through the Company Program. HMO coverage also offers physician's office visits and preventive care.

Navistar will pay the premium for the Health Maintenance Organization (HMO) coverage up to the cost the Company would have incurred if the retiree or surviving spouse were covered by the Company Program. HMO premiums in excess of the cost of the Company Program are the responsibility of the retiree or surviving spouse, and are payable to the Company.

Coordinated Care Program

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Quality care and cost reduction in the medical system are common concerns of Navistar and retirees. We believe that an emphasis on quality will enhance the health status of individuals, and will result in lower medical costs. Therefore, Navistar and the UAW agreed to jointly develop a coordinated system of medical care for non-Medicare-eligible retirees and surviving spouses through Coordinated Care Networks.

Medical

Medical Plan 1

A Coordinated Care Network is a group of physicians, hospitals, and other health care service providers who practice within a specific geographical area. These providers have agreed to provide medical care to Navistar retirees, surviving spouses and their dependents using specific quality guidelines and agreed-upon prices.

The Coordinated Care system will:

- ✔ provide the highest quality of care, and incorporate the most effective methods for evaluating and monitoring the quality of the health care system,
- ✔ coordinate all aspects of patient treatment plans, including ongoing assessment by the primary care physician of the care received from the range of network providers,
- ✔ promote wellness, health awareness, and preventive practices,
- ✔ provide educational materials to individuals so that they are able to make informed health care decisions,
- ✔ be easily accessible to patients,
- ✔ be cost-effective for the Company and patients, and
- ✔ derive its cost reductions from quality improvements and discounted fee arrangements with providers.

Scope of Program

The Coordinated Care Network will include a broad range of health care providers and services, including:

- ✔ physicians,
- ✔ hospitals,
- ✔ laboratories and radiology centers,
- ✔ outpatient surgical centers,
- ✔ skilled nursing and home care services,
- ✔ dental/vision/hearing services (on a retiree-paid basis),
- ✔ psychiatric and substance abuse programs,
- ✔ hospice facilities,
- ✔ pharmacies, and
- ✔ physical, occupational and speech therapists.

Home Health Care and Hospice benefits will only be available instead of hospitalization on a pre-authorized basis. For information regarding Home Health Care and Hospice benefits, contact the Sunderbruch Corporation at **1-800-373-1020**.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

Joint Determination

The Joint Navistar/UAW Committee on Health Care will be responsible for all aspects of the design, implementation, oversight and modification of the Program, including the responsibility to:

- ✔ select medical and utilization review vendors and providers,
- ✔ select program implementation dates in all cases,
- ✔ choose applicable quality measurements and independent quality auditors,
- ✔ set access standards,
- ✔ determine administrative practices and standards, and
- ✔ monitor ongoing effectiveness of the network.

If the Joint Navistar/UAW Committee on Health Care fails to act, or ceases to exist, these duties will become the responsibility of the Health Benefit Plan Committee.

In establishing the Coordinated Care system, the Joint Navistar/UAW Committee on Health Care will choose certain geographic areas with large numbers of retirees for network development. The Committee will approve the selection of the hospitals and physicians who will be a part of the network. When the system is developed in a specific geographic area, you will be notified directly and the following guidelines will apply:

1. Retirees within the designated network area may choose to use either network or non-network providers.
2. Retirees in the network areas who use network providers will have their health care claims reimbursed at the levels described in this book. These retirees also will have access to discounted physician office visits.
3. Retirees within the network area who do not use network providers will have to pay a 25% copayment for all medical services provided outside the network, instead of the 20% copayment described in this book. The Out-of-Pocket Maximum for each covered person will remain at **$500**.
4. Retirees who live outside the designated network areas may choose to use either network or non-network providers without penalty. These retirees will also have access to discounted physician office visits.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

Health Care Quality

The Coordinated Care Program will emphasize quality and continuous improvement. The network will use quality measurements and initiatives such as:

- ✔ physician credentialing and recredentialing information, including:
  - board certification, licensure, malpractice coverage and history, education, hospital affiliation, hospital and physician peer review, and analysis of hospital and office treatment patterns, and
  - publicly available provider and Navistar data for use in the selection of hospitals and other health care providers.

Access Standards

A major consideration in selecting providers will be retiree access to medical care. The parties will examine current health care practice patterns and the geographic dispersion of members in order to design a network which is accessible and preserves patient/provider relationships, wherever possible. Service areas will be established using as the basis in each case reasonable travel time for patients to visit network providers.

The following standards will be used by the parties in establishing such service areas:

- ✔ primary care physicians within **fifteen (15) minutes** travel time or **five (5) miles** from the retiree's residence
- ✔ emergency care within **fifteen (15) minutes** travel time from the retiree's residence
- ✔ elective hospital care within **thirty (30) minutes** travel time from the retiree's residence
- ✔ tertiary care within **forty-five (45) minutes** travel time from the retiree's residence
- ✔ specialists within **thirty (30) minutes** travel time from the retiree's residence
- ✔ network providers will be chosen who have sufficient capacity for new patients and waiting times for appointments will be reasonable

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

- ✔ emergency services available **twenty-four (24) hours** a day
- ✔ urgent care services will be available on the same day and the network will have physicians on-call and available **twenty-four (24) hours** a day for such care
- ✔ initial visit with primary care physicians available within **ten (10) days**
- ✔ follow-up visits will be scheduled based on the treatment and/or the condition

Retirees who reside within the service area will have a choice of at least **three (3)** primary care physicians with sufficient capacity for new patients.

The Joint Navistar/UAW Committee on Health Care will have the authority to modify the guidelines listed above, if appropriate.

The network will include an appropriate number of primary care physicians, specialists, and other providers for the patient population. Retirees will be encouraged to select a primary care physician and will be allowed to change that selection at any time.

Primary care physicians within the network will refer retirees to network specialists whenever possible. However, if the particular specialty is not available within the network, or if a referral is made outside the network, the benefit will be fully paid. Retirees will also have direct access to all network providers.

The Joint Navistar/UAW Committee on Health Care will develop reasonable standards for the following situations:

- ✔ Coverage for dependents attending schools outside the network service area,
- ✔ Initial transitional rules for patients receiving a course of treatment from a provider who does not become a network provider,
- ✔ Transitional rules for retirees receiving treatment from providers who drop out of the network, and
- ✔ Retirees with partial year residence changes.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

Administration

Network administrative goals include:

- ✔ timely and accurate claims processing
- ✔ reduced paperwork for retirees
- ✔ elimination of medical necessity and reasonable and customary disputes with network providers, and
- ✔ expedited resolution of disputes.

The Committee will establish a process to settle claim disputes quickly and fairly, and will monitor administrative performance through measures such as:

- ✔ speed of claims and appeals processing
- ✔ response time to claim inquiries, and
- ✔ patient satisfaction surveys.

In addition, should a dispute arise as to the design, implementation or administration of the coordinated system of medical care for retirees described, it shall be referred to the Committee for resolution. There will be no monetary penalties or disturbance of patient/provider relationships pending final resolution of the dispute.

Psychiatric/Substance Abuse Provisions

In some cases, it will not be possible to designate a Coordinated Care Network for psychiatric and substance abuse treatment. In those areas the Joint Committee will:

- ✔ identify and encourage the use of quality providers, and
- ✔ develop guidelines for effective use of inpatient confinement, outpatient treatment and after-care.

If the Committee fails to act, or ceases to exist, the Health Benefit Plan Committee will assume these responsibilities.

Important Note:
The Coordinated Care Networks are in the process of development. You will be notified when they are completed.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

Cardiac Centers of Excellence

Cardiac Centers of Excellence are designed for the elective surgical and medical treatment of cardiac illnesses. These Centers will be established in each of Navistar's major manufacturing locations in the United States.

Here's How the Program Works:

1. First, your physician must identify the need for cardiac and/or surgical care.
2. Next, call Sunderbruch at **1-800-373-1020.** A Sunderbruch nurse will guide you through the program to be sure you understand how it works and to answer any questions you might have.
3. Then, you must decide if you want to participate in the program. Participation is voluntary. You will receive the same benefits whether you choose to be treated at a hospital of your choice, or at a hospital in the Centers of Excellence program.

Individual Case Management

Individual Case Management (ICM) is available to Navistar retirees and family members covered under Medical Plan 1. It is especially valuable when illnesses, injuries or diseases require prolonged and/or expensive care.

An Individual Case Management program enables you to receive medical care in alternative settings, and receive coverage for expenses which may not be included on the list of treatments, facilities, services or supplies that Medical Plan 1 usually covers. Each case will be considered based on its individual circumstances.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

The ICM program is arranged by Sunderbruch, our utilization management administrator. You, your family, and your physician make the final decisions about your treatment plan. **Treatment must be approved by Navistar, Aetna, or Sunderbruch. Treatment that is prohibited by law will not be covered.**

Here's how the ICM program works.

- ✔ **Evaluation** — Through a review of claims and medical services used, certain extended hospital stays, illnesses or injuries are identified that might be effectively addressed by an ICM program.
- ✔ **Coordination** — If you or a family member receives treatment for certain illnesses or injuries, physicians and nurse consultants work with you, your physicians, your family and Navistar to arrange for quality care—perhaps in alternative settings not typically included in Medical Plan 1.
- ✔ **Treatment Program** — A recommended treatment program will be developed. It will authorize coverage for medical care in alternative settings, which can include certain expenses not typically covered under Medical Plan 1.
- ✔ **Approval** — The treatment program must be approved by all parties. These include the person being treated (or an authorized family member or legal guardian); the physician(s); the medical facility; Sunderbruch, Aetna, or Navistar.
- ✔ **Agreement** — An agreement letter must be signed by all parties approving the treatment plan, and a copy sent to the Claim Office.
- ✔ **Review** — Each case will be continuously reviewed to assure that the site and method of treatment remain appropriate.

Note:
If alternative coverage is provided in a particular situation, it should not be considered a precedent in the determination of medical expense coverage provided under Medical Plan 1 for another person, or for the same person at another period of time. Each case will be considered based on its individual circumstances.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

Home Health Care

Home Health Care is the extension of care services into an individual's home as an alternative to hospitalization or convalescent care. Home Health Care is only provided on a pre-authorized basis. For information regarding Home Health Care, contact the Sunderbruch Corporation at **1-800-373-1020**.

Patients must be referred to the Home Care program by their physician(s), and the alternate treatment plan must be mutually agreed to by the patient, family and physician.

Home Care can include:

- ✔ Nursing care services
- ✔ Home Health Aide services
- ✔ Physical Therapy
- ✔ Occupational Therapy
- ✔ Speech Therapy
- ✔ Medical Social Services
- ✔ Dietary Guidance

Some services not included as part of Home Care are:

- ✔ Custodial care
- ✔ Baby sitting services
- ✔ House cleaning
- ✔ Transportation

The Home Care program should be centrally administered and include individual planning, evaluation and follow-up procedures that provide for physician directed medical, nursing and related services.

Home Care Agencies may be hospital based or other certified Home Health Care Agencies that are approved by the plan administrator. A Home Care Agency or organization must meet all of the following:

- ✔ It is primarily engaged in, and duly licensed by the appropriate licensing authority to provide, skilled nursing services and other therapeutic services.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

- ✔ It has policies established by a professional group associated with the agency or organization. This professional group must include at least one (1) physician and at least one (1) registered graduate nurse (R.N.) to govern the services provided. The professional group must also provide for full-time supervision of such services by a physician or registered graduate nurse.
- ✔ It maintains a complete medical record on each individual.
- ✔ It has a full-time administrator.

Home Care Agency Services

The following Home Care Services may be provided to the patient through the Home Care Agency:

- ✔ **Nursing Care**

  Includes all medically necessary nursing care which may be readily provided within the patient's home as part of the total physician-directed prescribed plan of treatment. It includes coordinating the patient's health care program by evaluating and channeling appropriate information to other members of the health care team, administering medication, assisting with rehabilitative or terminal care, instructing and guiding the patient and family in procedures resulting in greater self-sufficiency and other essential nursing services and professional care of the degree of intensity provided for by the Program. Examples of these services would be changing dressings, administering injections, teaching self-administration of insulin and other injectables, evaluating the patient's condition, and advising the patient's attending physician of the patient's progress within the treatment plan.

- ✔ **Physical Therapy**

  Includes all therapy deemed essential to the treatment of the patient when determined and prescribed by the attending physician and the Home Care Agency. Emphasis is on restorative and rehabilitative services which may easily be provided within the patient's home, making the patient more self-sufficient. This includes implementing, teaching, evaluating and supervising, and when necessary, it also includes exercise regimens for strengthening and maintaining muscles, gait training, prosthetic device training and instructing a responsible family member in routine exercises to maintain the patient's strength and range of motion.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

✔ **Occupational Therapy**

Occasionally, if appropriate, an occupational therapist may provide therapy services such as evaluating the vocational possibilities of the patient, teaching household activities commensurate with the disability, teaching substitution for non-functioning parts of the body or stimulating the patient's interest in purposeful activity.

✔ **Speech Therapy**

Speech therapy consists primarily of correcting or restoring the patient's vocal patterns following illness or injury.

✔ **Social Service Guidance**

The focus is on evaluating personal, emotional, social and environmental circumstances related to, or resulting from, a patient's illness and correcting those factors which may further complicate or hinder a favorable response from medical treatment, as requested and directed by the patient's personal physician.

✔ **Dietary Guidance**

Includes the evaluation and recommendation of relevant diet regulation and menu preparation for the patient by nutritionists and dieticians and instructing the patient and/or a responsible family member who understands the dietary and nutritional requirements within the medical treatment plan.

✔ **Home Health Aide Service**

This service is intended for patients whose families are unable to provide this service for them and is provided only if the agency determines that the particular patient could not be on Home Care without such service. A Home Health Aide must be in the employ of the Home Care agency and have received special training in the care of the sick. The aide gives such non-professional care to the patient as is necessary when performed upon medical recommendation and under appropriate supervision of the Home Care nurse.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

Home Health Aide services may include:

- ✔ Changing patient's bed linen, cleaning equipment and maintaining patient's unit.
- ✔ Charting and monitoring the patient's vital signs and any changes in condition.
- ✔ Preparing meals according to diet prescribed by the attending physician.
- ✔ Assisting the patient:
  - with bathing, skin and mouth care, care of eyeglasses, hair and nails.
  - with use of the bed pan, commode, or bathrooms.
  - in and out of bed or chair (including wheelchair), and in walking.
  - to carry out simple prescribed activities as directed by the physician and under the supervision of a registered nurse.
  - to relearn the normal activities of daily living and household skills.
  - with the application of heat or cold as a comfort or therapeutic measure as instructed by the physician.
  - in proper position in a bed or chair by lifting (non-ambulatory patients), as directed by appropriate professional person.

Home Care expenses are charges made by a Home Health Care agency for services and supplies furnished to an eligible patient in accordance with the agreed-upon care plan.

These can include:

- ✔ Part-time or intermittent nursing care by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.)
- ✔ Part-time or intermittent Home Health Aide services which consist primarily of caring for the patient
- ✔ Physical therapy, occupational therapy, speech therapy, medical social services, and dietary guidance
- ✔ Medical supplies, drugs, and medicines prescribed by a physician, laboratory services provided by or on behalf of a hospital, but only to the extent that such charges would have been covered under this Program if the patient had remained in the hospital or convalescent facility.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

Hospice

Hospice addresses the needs of terminally ill patients who wish to select alternative care arrangements. Hospice care is provided only on a pre-authorized basis. For information regarding Hospice care, contact the Sunderbruch Corporation at **1-800-373-1020.**

Hospice care can include:

- ✔ bereavement counseling
- ✔ care rendered in a nursing home facility with hospice support
- ✔ respite care
- ✔ nursing care provided by, or under the supervision of, a registered nurse
- ✔ medical social services provided by a social worker under the direction of a physician
- ✔ physician services
- ✔ counseling services provided to the patient, family members and/or other persons caring for the patient at home
- ✔ general inpatient care provided in a hospice inpatient unit
- ✔ medical appliances and supplies
- ✔ physical, occupational and speech therapies
- ✔ home health aide services
- ✔ continuous home care provided during periods of crisis, as necessary, to maintain a patient at home

Admission to a Hospice program requires an order of a physician who certifies that the patient requires the type of care available through the Hospice and that the patient has a life expectancy of **six (6) months** or less. The Hospice services that are provided and billed by the Hospice Care Agency must meet standards that are approved by the Program.

When care is provided in a nursing home facility with Hospice support, it means that care is being provided to a patient who is medically stable, but cannot go home because there is no one available to care for that patient at home and the patient cannot take care of himself or herself. Short-term inpatient care or "respite care" is provided only when necessary to relieve family members or other caretakers at home. Bereavement counseling is available to the patient's family after the patient's death.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

A Hospice Care Agency or organization is required to:

- ✔ have Hospice care available **twenty-four (24) hours** a day
- ✔ meet licensing or certification standards set forth by the jurisdiction where it is located
- ✔ provide
  - skilled nursing services
  - medical social services
  - psychological and dietary counseling
  - bereavement counseling for the immediate family
- ✔ provide or arrange other services which include:
  - services of a physician
  - physical or occupational therapy
  - part-time Home Health Aide service which mainly consists of caring for terminally ill individuals
  - inpatient care in a facility when needed for pain control
- ✔ have personnel which include at least:
  - one (1) physician
  - one (1) registered nurse (R.N.)
  - one (1) licensed or certified social worker employed by the agency
  - one (1) pastoral or other counselor
- ✔ establish policies governing the provision of Hospice care
- ✔ assess the patient's medical and social needs
- ✔ develop a Hospice Care Program to meet those needs
- ✔ provide an ongoing quality assurance program. This includes review by physicians other than those who own or direct the agency
- ✔ permit all area medical personnel to utilize its services for their patients
- ✔ keep a medical record on each patient
- ✔ utilize volunteers trained in providing services for non-medical needs
- ✔ have a full-time administrator

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

The Hospice Care Program should include a written plan of Hospice care which:

- ✔ is established by, and reviewed periodically by, a physician who is attending the patient, and also by appropriate personnel of the Hospice Care Agency.
- ✔ is designed to provide palliative and supportive care to terminally ill individuals, and supportive care to their families.
- ✔ includes an assessment of the individual's medical and social needs, and a description of the care to be rendered to meet those needs.

* These special requirements for Plan 1 DO NOT APPLY TO PLAN 2.

Medical

Medical Plan 1

Covered Medical Expenses

Plan 1 provides coverage for a broad range of expenses for certain hospital, surgical, and medical services and supplies. These must be provided for the treatment of a non-occupational injury or disease.

Plan 1 will pay a percentage of the Reasonable and Customary charges for the following services and supplies if they are considered medically necessary. Refer to the "Summary of Benefits: What Plan 1 Pays" chart for more information.

1. **Ambulance Services**

   If you or a covered dependent is confined in a hospital, the Program covers charges for medically necessary transport by a professional ambulance service, including air ambulance:

   - ✔ to or from the hospital,
   - ✔ for transfer to another hospital, or
   - ✔ from a hospital to a facility for a CAT scan.

2. **Anesthesia Services**

   The Reasonable and Customary charges for the services of a physician anesthesiologist are covered, as long as they are administered along with other covered services.

   These include the services of:

   - ✔ a licensed physician (who is not the operating surgeon), or
   - ✔ a licensed Doctor of Dental Surgery who is not the operating surgeon and only if the surgery is performed in the hospital
   - ✔ a qualified registered nurse (who is not an employee of the hospital) if the same services would qualify for benefits when performed by a physician anesthetist

3. **Chemotherapy**

   Charges for medically accepted chemotherapy treatment will be covered if the retiree or dependent undergoes treatment by a physician for malignancies. This treatment must be administered and charged for by a physician, or administered in the outpatient department of a hospital and charged for by the hospital. Payment may be made directly to the physician or hospital, and will include the chemicals or other substances used in the treatment, and any facility charges associated with the treatment.

Medical Plan 1

4. **Consultation Services**

   If the patient is confined as a bed patient in a hospital or an approved convalescent facility, coverage is provided for consultation services of a physician if requested by the physician in charge of the case. These services are generally required for assistance in the diagnosis or treatment of a condition requiring specialized skills or knowledge. Fees of staff consultants required by the hospital's rules and regulations are not covered. Outpatient consultations also are not covered.

5. **Convalescent Care Facilities**

   Convalescent Care Facility benefits will be paid only if the patient is under the care of a physician who certifies that continuing skilled nursing care is essential. Also, the Facility must be recognized as an approved Facility by Aetna.

   An Approved Convalescent Facility is "an institution which meets all the standards for, and has been certified to be, an extended-care facility accredited by the Joint Commission for the Accreditation of Health Care Organizations." It can also be an institution that has been recognized by the United States Department of Health, Education and Welfare as being in compliance with the conditions of participation of extended-care facilities under the Federal Medicare Act. Call the Navistar/ Aetna Benefits Payment Office in Rockford **(1-800-435-2969)** to find out if a facility is approved.

Call 1-800-435-2969 to find out if a Convalescent Care Facility is "approved."

Medical

Medical Plan 1

To maintain your eligibility for benefits, the physician must:

- ✔ Visit and treat the patient **at least once every two weeks.**
- ✔ Recertify the continuing need for convalescent confinement **at least every 30 days.** At each recertification the physician must furnish a current diagnosis and prognosis.

Benefits (other than for a mental or nervous disorder) are available if the reason for the confinement meets one of the following requirements:

- ✔ Convalescence is for an injury or disease with a good prognosis for recovery. The type and extent of care required must be less than what is available in an acute general hospital, but greater than what is possible at home.
- ✔ You, or your covered dependent, is bedridden with a long-term illness requiring the same intensity of care needed for a convalescent patient.
- ✔ The confinement is for a terminal illness with a short-term life expectancy.

Two other requirements must be met to qualify for Convalescent Facility benefits for a mental or nervous disorder:

- ✔ First, the confinement must immediately follow a transfer from a hospital for active treatment of the disorder.
- ✔ Second, admission to the Convalescent Facility must be for short-term care, and the prognosis for recovery or improvement must be good.

Medical

Medical Plan 1

Benefit Period. Benefits are paid (with the exception of confinements for mental or nervous disorders) for up to **730 days** during any one continuous period of disability. If Convalescent Care is required for a mental or nervous disorder, the benefit period is **90 days** per calendar year, and hospitalization must immediately precede the Convalescent Care confinement. Benefits paid under prior Navistar plans count against this current Program maximum.

The maximum benefits payable, as stated above, are for a period of disability. The maximum days of confinement in an Approved Convalescent Facility will be reduced by two days for each day of hospital confinement for the same period of disability. Each day of hospital confinement will count as two days of confinement in an Approved Convalescent Facility, as well as two nights of night care treatment in a night care treatment program.

Convalescent Care Benefits. A new benefit of **730 days** begins after at least **60 days** have passed since the last confinement in a hospital, Approved Convalescent Facility or night care center. A new benefit of **90 days** for mental or nervous confinement will begin the next calendar year.

A night care center is a Facility, either associated with a hospital or approved by Aetna, that has a professional staff whose primary purpose is to provide a planned program of psychiatric services for mentally ill patients during the evening and night hours.

Other Services and Supplies. The Program covers charges for a semi-private room or ward. If you are in a private room, the benefit will be equal to the Facility's most common charge for a semi-private room. General nursing care, meals and special diets are also covered.

Medical

Medical Plan 1

Coverage includes benefits for necessary services and supplies of the Convalescent Facility, as long as they are directly related to your treatment during confinement. These include:

- ✔ Special treatment rooms
- ✔ Routine laboratory exams
- ✔ Physical, occupational, or speech therapy treatment
- ✔ Oxygen and other gas therapy
- ✔ Drugs, biologicals, and solutions used during convalescence in the Facility
- ✔ Dressings and casts

When Benefits Are Not Payable. No benefits will be paid for a stay in a Convalescent Facility if either of the following conditions apply:

- ✔ The maximum level of recovery possible has been reached, and treatment other than routine, supportive care is no longer needed, or
- ✔ For the most part, care is Custodial Care.

Custodial Care means care made up of services and supplies that are furnished primarily to train or assist in personal hygiene or other activities of daily living, rather than to provide therapeutic treatment. Custodial Care can safely and adequately be provided by individuals who do not have the technical skills of a covered health care provider:

Activities of daily living include such things as:

- ✔ bathing,
- ✔ feeding, and
- ✔ taking oral medicines.

This type of care is custodial regardless of who recommends, provides or directs the care, where the care is provided or whether or not the patient can be or is being trained to care for himself.

No benefits will be paid if:

- ✔ The illness being treated is principally a mental illness that does not qualify for short-term Convalescent Care,
- ✔ The condition being treated is principally pulmonary tuberculosis, senile deterioration, mental deficiency, mental retardation, or the Facility is primarily providing special education.

Other expenses not covered include:

- ✔ Expenses that are not billed as regular institutional care, such as personal grooming services, convenience items and telephone charges.
- ✔ Care given before the date the Facility was recognized by Aetna as an Approved Convalescent Facility.

Physician's services. The plan provides coverage for all Reasonable and Customary charges for the services of the physician in charge of the case when you (or an eligible dependent) are eligible for Approved Convalescent Facility benefits.

These benefits are limited to two visits each week, with a maximum of **208 visits** during any one continuous period of disability. In the case of a confinement for mental or nervous disorders, the maximum number of visits is **26**. The maximum number of visits will be reduced by one for each hospital visit during the same continuous period of disability.

A new maximum will apply after at least **60 consecutive days** have gone by since the last confinement in a hospital, a night care center, or an Approved Convalescent Facility. (Exception: mental or nervous confinements are subject to a 90 day per calendar year maximum.)

6. **Durable Medical Equipment**

Durable medical equipment (things like a hospital bed or wheelchair) means medical equipment which fully meets all of the following tests:

- ✔ can withstand repeated use,
- ✔ is primarily and customarily used to serve a medical purpose,
- ✔ is generally not useful in the absence of a disease or injury, and
- ✔ is appropriate to medical treatment at home.

Medical

Medical Plan 1

Charges for the rental of durable medical equipment for inpatient or outpatient use are covered when prescribed by a physician (MD or DO). The Program will cover the purchase of equipment if Aetna determines the purchase is more cost-effective than rental, based on the duration of need. However, the Program will not cover special features added to durable medical equipment if, as determined by Aetna, their purpose is for personal comfort and convenience, unless medically necessary.

Durable medical equipment includes:

- ✔ items used for iron lungs
- ✔ hospital-type beds and equipment
- ✔ crutches
- ✔ walkers
- ✔ inhalators
- ✔ suction machines
- ✔ circulatory aids
- ✔ negative pressure ventilators
- ✔ home glucose monitors and related supplies (with modification for the sight impaired)
- ✔ portable insulin infusion pumps (for certain diabetic conditions)
- ✔ standard non-deluxe travel chairs (for handicapped children ages 2-14)
- ✔ continuous positive air pressure machines
- ✔ continuous passive motion machines
- ✔ ultra filtration monitors
- ✔ oxygen tents
- ✔ neuromuscular stimulants
- ✔ canes
- ✔ nebulizers
- ✔ toilet aids
- ✔ wheel chairs
- ✔ traction equipment
- ✔ lambswool pads (for prevention of bed sores)
- ✔ lymphedema pumps (as defined by the Medicare screening list for durable medical equipment)
- ✔ electromagnetic bone growth stimulators (for certain severe fractures)
- ✔ bead seats (in connection with a covered child's wheelchair)
- ✔ phototherapy lights and photometers
- ✔ transtracheal catheters

Durable medical equipment does not include:

- ✔ dentures, hearing aids, eyeglasses or contact lenses,
- ✔ equipment which is primarily and customarily used for non-medical purposes, such as:
  - heat lamps, air conditioners, room heaters, and other devices and equipment used for environmental control or to enhance the environment in which the patient is placed, such as dehumidifiers, and
  - face masks, elastic stockings, arch supports, irrigating kits, ace bandages, or any other device or equipment which is used primarily for comfort or convenience.

7. **Emergency Care**

   The Program covers a percentage of the Reasonable and Customary charges for Emergency Care if it meets the Program's definition:

   "the sudden and unexpected onset of, or significant increase in, symptoms which require immediate medical care which the patient seeks promptly after the onset or increase in symptoms or as soon thereafter as care can be made available." Medical emergencies include heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, rabies immunizations, and other such acute conditions as may be determined to be medical emergencies by the Company or insurance company.

   Coverage will be provided for Emergency Care expenses related to the necessary diagnosis or emergency treatment of a non-occupational disease or an accidental injury, excluding follow-up care. If the care is provided in an emergency room, the condition must be severe enough to require care in that setting, as opposed to a physician's office. See the "Outpatient Hospital" section, pages 75-76, for the limitations applied to Emergency Care.

8. **Free-Standing Surgical Facility**

   Benefits will be paid for charges in connection with a surgical procedure performed in a Free-Standing Surgi-Center for those procedures which would otherwise require the services of the outpatient department of a hospital, or that would be performed on an inpatient basis.

Medical

Medical Plan 1

9. Home Hemodialysis

Expenses directly related to equipment and supplies for Home Hemodialysis treatments are covered. There is no coverage for whole blood. See page 75 for other "Outpatient Hemodialysis" benefits.

10. Hospital Pre-admission Testing

The Program covers actual charges for required tests performed within 7 days of hospital admission. The Pre-admission tests must be:

- ✔ required by the hospital, or
- ✔ related to patient's condition or diagnosis, and
- ✔ ordered by the physician in charge.

If the **physician cancels** the hospitalization, charges for the tests will be covered.

If the **patient voluntarily cancels** the hospitalization, charges for the tests will not be covered.

11. Hospital Room and Board

The Program covers Room and Board charges for the facility's most common semi-private room rate.

- ✔ Precertification is encouraged for all hospital stays.
- ✔ Coverage is for certified days as necessary (no limit).
  - If it is certified in writing by the Admitting Office of the hospital that semi-private accommodations are not available at the time of admission and thereafter, the benefit payable for the day or days that semi-private accommodations are not available will be an amount equal to the hospital's regular daily rate for the lowest priced private room that is available when you are initially confined. The terms of this paragraph will not apply to a hospital unless at least 50% of its accommodations are ward and/or semi-private rooms.
- ✔ If a hospital's specific isolation facilities are utilized for the necessary treatment of infectious disease or for diagnosis requiring such specific facilities, the Room and Board charge including the cost of special nursing and isolation unit supplies, will be covered.
  - If specific isolation facilities are not available, resulting in use of a private room, Room and Board benefits will be paid in an amount not to exceed the rate most commonly charged by the hospital for private accommodations.

For the inpatient or residential treatment of substance abuse, the Program covers Room and Board expenses up to a maximum of **35 days** per calendar year.

For the inpatient or residential treatment of mental and nervous disorders, the Program covers Room and Board expenses up to a maximum of **60 days** per calendar year.

12. In-hospital Physician Services

The Program covers in-hospital services performed by a physician while the patient is confined as a bed patient in a hospital.

13. Mammography Services

The Program provides coverage for Diagnostic Mammograms and Routine Screening Mammograms, as follows.

- ✔ **Diagnostic Mammograms:** A Diagnostic Mammogram is one ordered by a physician in response to a specific symptom of an illness, such as a lump in the breast. Coverage for a Diagnostic Mammogram is at:
  - 80%, after deductible and copayment, and
  - is not subject to the age and frequency limitation schedule for Routine Screening Mammograms, and
  - need not be done at a specified provider.
- ✔ **Routine Screening Mammograms:** A Routine Screening Mammogram is part of a program of preventive care. It is a test that is performed on a person who has NO physical symptoms of breast disease. Routine Screening Mammograms are covered based on the following guidelines:

Age	Frequency
35-39	One Mammogram during this time
40-49	One every two years
50+	One every year

The Joint Navistar/UAW Committee on Health Care is responsible to select Mammography centers and to monitor the program. If the Joint Committee fails to act or ceases to exist, the Health Benefit Plan Committee will assume this responsibility.

Medical

Medical Plan 1

If you live in any of these ZIP code areas, you must use a designated facility, as agreed to by the Joint Navistar/UAW Committee on Health Care, for Mammography screenings.

If you live in any of the following metropolitan areas, specified by the ZIP code in which you reside, you must use one of the designated facilities in order to be covered. Eligible participants who live outside these areas may use one of the designated facilities or may choose any provider. Routine Screening Mammograms are not subject to deductible or copayment provisions, and are paid at 100% when you follow the Program guidelines.

For those living in Chicago, Ft. Wayne, Waukesha, Indianapolis and Springfield, specific providers have been designated for Routine Screening Mammograms. These providers are listed in the following chart.

If You Live in One of These Metropolitan Areas...	You Must Use One of These Designated Facilities
Ft. Wayne (ZIP codes 46700 to 46899)	Breast Diagnostic Center 1902-A Carew Street Ft. Wayne, IN 46805 (219) 483-1847
Waukesha (ZIP codes 53000 to 53299)	Columbia Hospital 2025 E. Newport Avenue Milwaukee, WI 53211 (414) 961-3841
Indianapolis (ZIP codes 46000 to 46299)	Indianapolis Diagnostic Breast Center Penbrook Medical Building 1950 West 86th Street Indianapolis, IN 46260 (317) 872-3583

Chart continued on next page.

Medical

Medical Plan 1

Chart continued from previous page.

If You Live in One of These Metropolitan Areas...	You Must Use One of These Designated Facilities
Chicago & Suburbs (ZIP codes 60000-60699)	Health Awareness Center 1815 S. Meyers Road Oakbrook Terrace, IL 60181 (708) 969-8558
Northwest Indiana (ZIP codes 46300-46499)	Grove Radiology Grove Medical Center Route 83 and Robert Parker Coffin Road Long Grove, IL 60047 (708) 634-2520 Northwestern Memorial Hospital Wesley Pavilion 250 E. Superior Chicago, IL 60611 (312) 908-6366 High Tech Medical Park 11800 Southwest Highway Palos Heights, IL 60463 (708) 361-0220
Springfield (ZIP codes 43000 to 43999, and 45300 to 45599)	Mercy Memorial Hospital Radiology Department 904 Scioto Street Urbana, OH 43078 (513) 653-5231, ext. 320 Mercy Medical Center, Inc. HERS Center for Women 1343 N. Fountain Blvd. Springfield, OH 45501 (513) 390-5030

14. Mental and Nervous Expenses/Substance Abuse

Expenses for the treatment of mental and nervous disorders (including substance abuse) are covered as follows:

- ✔ Inpatient hospital expenses are covered at 80% after the deductible and 100% after meeting the copayment maximum for up to a **60-day** confinement period per calendar year.
- ✔ Outpatient expenses are covered up to **52 visits** per calendar year. Benefit payment is equal to 50%, after deductible. Benefits will be payable for the following services which are billed for by a psychiatric physician as services for his/her private patients:
  - Individual psychotherapeutic sessions wherein a psychiatric physician evaluates or treats his/her private patient in his/her office or in an Approved Outpatient Psychiatric Facility in sessions which are of **twenty (20) minutes** duration or more.
  - Individual psychotherapeutic sessions wherein a psychiatric physician evaluates or treats his/her private patient in sessions of less than **twenty (20) minutes** duration, but only when the patient has been admitted and is confined as a partially hospitalized patient in a night care or day care treatment program in an Approved Outpatient Psychiatric Facility.
  - Family counseling services wherein a psychiatric physician counsels in his/her office or in an Approved Outpatient Psychiatric Facility with the members of his/her private patient's family.
  - Group psychotherapeutic sessions wherein a psychiatric physician evaluates or treats his/her private patients in his/her office or in an Approved Outpatient Psychiatric Facility.
  - Psychological testing by a psychologist when such testing is prescribed by a psychiatric physician.
  - Electroshock therapy and anesthesia for electroshock therapy wherein such service is rendered in an Approved Outpatient Psychiatric Facility by a psychiatric physician.

Medical Plan 1

- All necessary professional and related ancillary services by an Approved Outpatient Psychiatric Facility to ambulatory patients through outpatient, day care and night care treatment programs. This includes, and is not limited to, psychological testing when administered by an employee of an Approved Outpatient Psychiatric Facility who is certified to administer psychological tests; and all necessary drugs and medications prescribed for treatment of mental illness by a psychiatric physician which are dispensed by an Approved Outpatient Psychiatric Facility.

Outpatient substance abuse expenses are subject to the same limitations, such as copayments and number of visits, as mental and nervous expenses as described on the previous page. Both outpatient mental and nervous and outpatient substance abuse visits are counted toward the same **52-visit** maximum per calendar year. For example, if you had **30** mental and nervous visits in a calendar year, Plan 1 would pay up to **22** outpatient substance abuse visits during that same calendar year.

Substance Abuse Program Benefits will be payable for services in a residential and/or outpatient chemical dependency treatment program if the patient has been examined by a physician and assigned a diagnosis of alcoholism or drug dependency as classified in categories 303.0-304.7 of the Eighth Revision. International Classification of Diseases Adapted for Use in the United States. U.S. Department Health, Education, and Welfare.

✔ **Approved Residential Facility Expense Benefit.** Benefits for treatment of chemical dependency will be payable if a retiree or dependent of retiree is confined as a patient in an Approved Residential Facility for which payment is not otherwise covered under Navistar International Transportation Corp.'s Retiree Health Benefit Program. Payment will be made for the actual fee or charge for covered services which are received in such a facility to the extent the fee or charge for such services is Reasonable and Customary and is no greater than the fee or charge to uninsured patients receiving the same services.

Medical

Medical Plan 1

Benefits will be payable for a maximum period of **35 days** for the following **seven (7) services** which are billed for by an Approved Residential Substance Abuse Facility as regular institutional care:

1) Room and Board will be deemed to include charges for rehabilitation and diversional equipment and supplies;
2) Laboratory tests;
3) Drugs, biologicals and solutions dispensed by the facility and used while the patient is in the facility;
4) All professional and other trained staff and ancillary services provided in the facility which are necessary for patient care and treatment. Ancillary services include all special services of the institution provided for the medical and rehabilitation care of persons with a chemical dependency problem;
5) Individual and group therapy, and counseling for family members of the patient undergoing treatment to the extent that such counseling is necessary and related to the treatment of the patient;
6) Psychological testing by an individual who is legally qualified to administer and interpret such tests. Where there are no licensure laws, the individual must be certified by the appropriate professional body for psychological testing;
7) Benefits for Outpatient care, if the patient is treated on an Outpatient basis.

- Days of confinement in a Hospital or an Approved Convalescent Facility will not be charged against the days available for Approved Residential Facility confinement. However, once the maximum **thirty-five (35) days** of benefits have been provided for a covered individual, a new **thirty-five (35) day** benefit period will not be granted until the next calendar year.

✔ **Outpatient Substance Abuse Facilities.**
Benefits for treatment of chemical dependency in an Approved Outpatient Facility will be payable under the Retiree Health Benefit Program for outpatient psychiatric benefits subject to the same limitations described above. Benefits will be provided for the following when billed for by the Facility:

- All professional and other trained staff and ancillary services provided in the Facility necessary for the treatment of the ambulatory patient. Ancillary services include all special services of the institution provided for medical and rehabilitative care of persons with a chemical dependency problem;
- Individual and group therapy, and counseling for family members of the patient undergoing treatment to the extent that such counseling is necessary and related to the treatment of the patient;
- Laboratory tests rendered in connection with the treatment received at the Facility;
- Drugs, biologicals, solutions and supplies dispensed by the Facility in connection with treatment received at the Facility, including drugs to be taken home;
- Psychological testing by an individual who is legally qualified to administer and interpret such tests. Where there are no licensure laws, the individual must be certified by the appropriate professional body for psychological testing.

15. Obstetrical Services

Coverage is provided for:

✔ all pregnancy-related visits to the physician's office,
✔ necessary laboratory tests,
✔ obstetrical services of a physician, and
✔ post-natal care.

Following birth, benefits are paid for necessary in-hospital physician care. This benefit does not include well newborn infant care, beyond an initial visit by a pediatrician. If the infant is premature or ill and requires hospitalization after the mother is discharged, charges for that care will be covered.

Legal abortions are covered by the Program.

16. Oral Surgery

The Program provides coverage for the following oral surgery procedures:

- ✔ excision of partially or completely unerupted impacted teeth,
- ✔ excision of erupted teeth where cutting into tissue, gum or bone is medically necessary for tooth removal,
- ✔ excision of the tooth root without the extraction of the entire tooth,
- ✔ closed or open reduction of fractures or dislocations of the jaw,
- ✔ other incision or excision procedures on the jaws and tissues of the mouth when extraction of teeth is not involved,
- ✔ any surgical procedure necessary to remove, repair, revise, reposition, or replace the jaw or the jaw joints, such as:
  - meniscectomy,
  - condylectomy,
  - arthrectomy,
  - high condylar shave,
  - joint implant
- ✔ the emergency repair of natural teeth due to accidental injury.

17. Organ or Tissue Transplants

- ✔ If a physician recommends that a covered person (retiree/dependent/surviving spouse) be confined as a resident patient in a hospital for the purposes of being a recipient of, or a donor for, an organ or tissue transplant surgical procedure, or if any other person is confined for the purpose of being a donor for the covered person, the charges will be payable as long as the donor is not otherwise eligible for benefits under any other Plan or coverage.
- ✔ If a covered person is confined, as described above, for the purpose of being a donor, and the donee has insurance which will cover the donor, benefits will not be paid by this Plan.
- ✔ In the event that a person is confined in a hospital, or is provided diagnostic services on an Outpatient basis, for the purpose of determining whether the person is a suitable donor, and the person is rejected for medical reasons, benefits will be paid to the same extent as if the person had been accepted as a donor.

In addition, the transportation of an organ or other body tissue for transplant surgery will be paid in full, but not in excess of the Reasonable and Customary charges for the service.

18. Outpatient Hospital

The Program covers Outpatient Hospital charges only for the following situations:

- ✔ Charges for Outpatient surgery are covered.
- ✔ Charges for Outpatient X-rays and lab tests are covered.
- ✔ Emergency treatment of accidental injuries is covered only if the treatment is received within 24 hours following the accident.
- ✔ Charges for the use of the Emergency Room for conditions which are a medical emergency are covered.
- ✔ Charges for hemodialysis are payable when billed for by the hospital as regular institutional care. When services are provided at the hospital on an Outpatient basis without actual admission of the patient, the reasonable charges of the hospital will be payable for the same services as are provided on an Inpatient basis. These include:
  - usage of equipment,
  - necessary laboratory tests,
  - nursing supervision,
  - drugs, and
  - central supplies (such as dialysis membranes, tubing, dressings and solutions, but not including whole blood).

A **medical emergency** is defined as, "the sudden and unexpected onset of, or significant increase in, symptoms which require immediate medical care which the patient seeks promptly after the onset or increase in symptoms or as soon thereafter as care can be made available." Medical emergencies include heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, rabies immunizations, and other such acute conditions as may be determined to be medical emergencies by the Company or insurance company.

Medical Plan 1

Conditions which are usually treated by a physician in the office such as colds, flu, migraine headaches, bladder infections, gastritis, etc., are generally not covered medical emergencies. Claims for emergency room services are subject to retrospective review and claim payment is based on the outcome of the review.

These Expenses Are Not Covered as Outpatient Hospital Care:

- ✔ Charges for an Outpatient consultation or examination by a salaried staff physician are not covered.
- ✔ Charges for using the facilities of the hospital for anything except surgery, chemotherapy, radiation therapy, hemodialysis, speech therapy, physical therapy, X-ray or lab tests, or emergency care, as described above, are not covered.

19. Outpatient Physical Therapy

Outpatient physical therapy services are covered for a period of up to **60 treatment days per 12-month period** when:

- ✔ they are prescribed by an M.D. or D.O. for a specified condition resulting from a disease or injury, or prescribed immediately following surgery.
- ✔ the services are performed in the Outpatient Department of a hospital, in an approved rehabilitation center, or in another center having comprehensive facilities and approved by Aetna for Outpatient physical therapy.

Outpatient physical therapy services must be performed by a physician (MD or DO) or a qualified physical therapist according to prescription from a physician concerning the nature, frequency and duration of treatment. A "qualified physical therapist" is a graduate of the program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association or its equivalent, and, where applicable, is licensed by the state.

The benefit also covers one consultation by a physician who specializes in medical rehabilitation or physical medicine during this **60-day** period.

The **60 treatment day limit** will be renewed, as follows:

- ✔ in the event of surgery, or
- ✔ if more than **twelve months** have elapsed since the last course of physical therapy treatment began, or
- ✔ in the event of another unrelated condition requiring physical therapy.

20. Outpatient Physician Services

The Program provides the following coverage:

- ✔ Outpatient surgery — surgical services will also be covered if provided by a duly licensed Doctor of Surgical Chiropody (Podiatry) (DSC) or by a duly liscensed Doctor of Dental Surgery (DDS).
- ✔ medically accepted forms of chemotherapy and radiological services for the treatment of malignancies.
- ✔ necessary and appropriate diagnostic X-ray and laboratory services.
- ✔ emergency treatment for situations, as described for covered expense #7 listed above.
- ✔ physician's services related to hemodialysis in the Outpatient department of a hospital or in the patient's home.
- ✔ physician charges for X-rays or lab work done on an Outpatient basis, excluding scopic procedures of the eye, ear, nose and throat performed in a physician's office or clinic, and endoscopy in connection with routine or periodic health evaluation.

Note:
Services and exams in connection with diagnostic, routine or periodic health evaluations are not covered. This includes routine physicals and routine exams such as school exams, employment exams, or routine immunizations. These expenses are not covered regardless of whether these services are provided in the doctor's office, a clinic or in the Outpatient department of a hospital.

21. Pap Tests, Routine

The Program covers one routine Pap test per calendar year at 80% after deductible and copayment. Coverage includes the physician's charge for taking the Pap and the corresponding lab charge for analyzing it.

Charges for an annual physical exam are not covered.

> **Note:**
> The one calendar year time frequency limitation does not apply to a Pap test performed for diagnostic purposes.

22. Private Duty Nursing

The Program covers professional Outpatient and Inpatient private duty nursing services.

Outpatient coverage is provided only if all of the following conditions are met:

- ✔ ordered by a physician,
- ✔ provided by a licensed registered nurse who does not normally reside with the patient and is not a member of the patient's family, and
- ✔ provided at a level that requires the special skills and knowledge of a registered nurse, as determined by Aetna.

Inpatient coverage is provided for private duty nursing services during confinement in a health care facility only when the care required is more than what the regular staff members would generally provide. The licensed registered nurse cannot:

- ✔ be a member of your family,
- ✔ reside in your home, or
- ✔ be an employee or a member of the staff or facility where you are confined.

23. Prosthetic and Orthotic Devices

Prosthetic Device means a device which replaces all or part of a body organ (including contiguous tissue) or a diseased, malformed, or injured portion of the body or replaces all or part of the function of a permanently inoperative or malfunctioning bodily organ, or portion of the body.

The Program covers:

- ✔ charges for prosthetic devices ordered by a physician (MD or DO),
- ✔ replacement of unusable prostheses or repairs ordered by a physician (MD or DO), and
- ✔ supplies and equipment necessary for the effective use of the prosthesis and which have no use other than in connection with prosthetic use.

Included are items such as:

- ✔ artificial limbs, eyes, ears, nose, larynx
- ✔ braces and other devices used to replace or make a part of the body functional
- ✔ trusses
- ✔ terminal devices such as hand hooks
- ✔ leg, arm, back and neck braces including foam neck collars
- ✔ scoliosis appliances
- ✔ external breast prosthesis (including the first two surgical bras designed exclusively for use with the prosthesis)
- ✔ orthopedic shoes and special insert pads for foot amputees (partial or full) covered once per year
- ✔ tracheostomy speaking valves, ostomy sets, urinary sets, blood pressure monitors for hemophiliacs, digital electronic pacemaker monitors, burn pressure gradient supports, and pressure gradient supports

- ✔ post-surgical lenses customarily used during convalescence from eye surgery in which the lens of the eye was removed, or used to replace a congenitally absent lens of the eye. In addition, combinations of prosthetic lenses are covered when determined to be medically necessary by a physician to restore essentially the vision provided by the crystallin lens of the eye.

The following are examples of some of the items **not** covered:

- ✔ eyeglasses used to correct vision,
- ✔ dentures and dental appliances,
- ✔ non-durable items such as support garments, special shoes (unless an integral part of a leg brace), and
- ✔ elastic support bandages.

24. Radiological Therapy

The Program covers charges for appropriate radiological therapy services performed by a physician, clinic or hospital while the patient is covered under the Program.

25. Residential Substance Abuse Treatment Facilities

Confinement in a residential substance abuse treatment facility is covered for up to a maximum period of **35 days** per calendar year. Confinement must be in a facility approved by Aetna.

26. Speech Therapy

Speech therapy, when prescribed by a physician and performed by a licensed, certified speech pathologist, is a covered service when directed to the active treatment of:

- ✔ disease (e.g., aphasia following a stroke),
- ✔ trauma (e.g., subdural hematoma influencing the speech center of the brain), or
- ✔ congenital anomalies (e.g., cleft palate) for children under six years of age, when coverage isn't available through public agencies.

Speech therapy sessions are limited to **30 days** per calendar year. Coverage for additional sessions will be considered on an individual basis if Aetna is furnished with satisfactory documentation of their necessity.

Speech therapy services are not covered for the following **four** conditions:

- ✔ delayed speech,
- ✔ behavior problems (including impulsive behavior and impulsivity syndrome),
- ✔ attention disorder, or
- ✔ mental retardation.

27. **Surgical Services**

The Program covers charges for the surgical services of a physician in performing a surgical procedure, including the usual and related pre-operative and post-operative care. Post-operative care shall be limited to the period of hospital confinement or to a period of not more than **30 days** following surgery, whichever is longer. Post-operative care beyond the **30-day limit** will be covered if related to unusual or complicated procedures for which the surgeon customarily makes a separate charge from the surgical fee. Coverage also includes:

- ✔ administration of an anesthetic, and
- ✔ technical surgical assistance by a physician who assists actively the primary surgeon in the performance of major surgery when it is medically necessary and appropriate, as determined by the insurance company. Covered individuals must be hospitalized when certification is made by the primary physician that services of interns, residents, or house officers were not available. No benefits will be payable unless the case is determined to be an exceptional circumstance, if the Reasonable and Customary charge is $125 or less.

Medical

Medical Plan 1

Surgical treatment of obesity by jejunoileostomy and incidental lipectomy will be covered only if both of the following conditions are met:

- ✔ Massive obesity — the patient's body weight is 100 lbs. or more above the optimal weight, and
- ✔ Medical Complications secondary to the obesity such as hypertension, diabetes, serious venous stasis, hyperlipidemia are present.

Benefits will not be provided when this procedure is performed for cosmetic reasons.

Procedures performed primarily to improve appearance are not covered.

Note:
You may be required to obtain a Second Surgical Opinion prior to having surgery. Turn to the "Second Surgical Opinion" section for information.

28. Voluntary Sterilization

Voluntary sterilization, such as a vasectomy or tubal ligation, is covered by the Program.

29. X-ray and Laboratory Tests

Charges for X-ray and laboratory tests in connection with the diagnosis and treatment of a disease, injury, or pregnancy are covered.

Medical

Medical Plan 1

These Expenses Are Not Covered by Plan 1

There are certain charges for Medical care that are not covered at all by Plan 1. Specifically, Plan 1 does **not** cover charges related to the following procedures or services.

1. **Anesthesia**
   Charges for anesthesia when administered in connection with a surgical procedure that is not covered under Plan 1.
2. **Cosmetic Surgery**
   Cosmetic surgery may be covered **ONLY** if the procedure :
   - ✔ corrects congenital anomalies, or
   - ✔ corrects conditions resulting from accidental injuries, or
   - ✔ corrects deformities resulting from disease or surgical scars.

   Charges for all other cosmetic or beautifying surgical procedures are excluded by Plan 1.
3. **Counseling**
   Charges for, or in connection with, marriage, family, child, career, social adjustment, pastoral or financial counseling services.
4. **Custodial Care**
   Charges for services, as determined by Aetna, that are Custodial Care or maintenance care. See the "Glossary" for a definition of Custodial Care.
5. **Dental**
   Charges for dental services and supplies that are not specifically rendered and received as surgical services and supplies.
6. **Education/Training**
   Charges for education, or special education, or job training, whether or not it is given in a facility that provides medical or psychiatric treatment.
7. **Emergency**
   Charges for the Emergency Room or for the services of emergency physicians for the treatment of a condition that is non-emergency in nature.
8. **Experimental**
   Charges for procedures, services, drugs and other supplies that are, as determined by Aetna, experimental.

Medical

Medical Plan 1

Note:
This exclusion will not apply to care, treatment, services or supplies (other than drugs) received in connection with a disease if Aetna determines that:

- the disease can be expected to cause death within one year, in the absence of effective treatment, and
- the care or treatment is effective for that disease or shows promise of being effective for that disease, as determined by scientific data. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals selected by Aetna, including professionals who treat the type of disease involved.

9. Eye Surgery

Charges for, or related to, eye surgery mainly to correct refractive errors. (Refractive errors are those that can be corrected with glasses or contact lenses.)

10. Felony

Charges for services and supplies received due to injury resulting from the commission of a felony by a covered person.

11. Government Services

- ✔ Charges for services provided by a government agency at no cost, except for Medicaid, and
- ✔ Charges for services received from a U.S. government hospital.

12. Legally Obligated to Pay

Charges for services and supplies that you or another covered person are not legally obligated to pay.

13. Medically Necessary

- ✔ Charges for services and supplies that are not necessary, as determined by Aetna, for the diagnosis, care or treatment of the physical or mental condition involved. This applies even if prescribed, recommended or approved by the attending physician. Denied charges fall under the Hold Harmless Provision of the Program. See pages 40-43 for more information.
- ✔ Charges for care, treatment, services, or supplies that are not prescribed, recommended and approved by the attending physician.
- ✔ Charges for drugs, medicines, appliances, indirect blood transfusions, materials or supplies, unless otherwise specifically provided in this booklet.

14. Pain Therapy

- ✔ Charges for acupuncture therapy UNLESS it is performed by a physician and used as a form of treatment in connection with surgery that is covered under this Program.
- ✔ Charges for subluxation and spinal manipulation.

15. Physician Services (Outpatient)

Physician office, clinic or Outpatient hospital visits, examinations, consultation or treatment (including injections), unless otherwise specifically listed as a covered service in this book.

16. Reasonable and Customary

For charges that Aetna determines are in excess of Reasonable and Customary guidelines. Denied charges fall under the Hold Harmless Provision of the Program. See pages 40-43 for more information.

17. Resident Physician/Intern

Charges for the services of a resident physician or intern rendered in that capacity.

Medical Plan 1

18. Routine Care/Screenings

Charges for:

- ✔ routine foot care (such as nail clipping and trimming of calluses),
- ✔ routine physical exams,
- ✔ routine vision or hearing exams, or hearing aids,
- ✔ routine dental exams,
- ✔ immunizations, except for rabies,
- ✔ screening tests (such as TB tine test, hepatitis or measles test) or screening X-rays, unless otherwise specifically provided by name in this booklet, or
- ✔ other preventive services and supplies, unless otherwise provided by name in this booklet.

19. Sterilization Procedures

Charges for the reversal of a sterilization procedure.

20. Vision/Dental/Hearing

Charges formerly paid under the Vision, Dental and Hearing plans are no longer covered. The Company intends to establish Vision, Dental and Hearing discount programs that will be made available to retirees.

21. Other

- ✔ Charges for services rendered and received before coverage under this Program becomes effective.
- ✔ Charges for services that are not for the treatment or diagnosis of a disease, injury or illness, or are not considered medically necessary.

Any exclusions named above will not apply to the extent that coverage is specifically provided by name in this booklet, or coverage of the charges is required under any law that applies to the coverage.

Medical

Medical Plan 1

How Plan 1 Benefits Are Coordinated

To avoid duplication of benefits — where two plans could cover the same medical expense — Medical Plan 1 has a Coordination of Benefits provision which is referred to as "100% Reimbursement COB."

One plan will be considered the "primary plan" and the other plan will be considered "secondary" in establishing the order of Benefit Payment. Refer to the section "Order of Benefit Payment" (see below) to understand which plan is primary and which plan is secondary.

The "primary plan" will pay benefits in a calendar year without consideration of any "other plan." When Plan 1 is the "secondary plan," it will pay any balance for covered expenses remaining after the annual deductible and copayments and after the primary plan has paid its share of the claim.

In other words, Plan 1, together with the primary plan, will pay up to 100% of all expenses covered by one or both plans. For example, if your spouse's insurance paid $80 on a $100 covered expense for your spouse, Plan 1 would pay the remaining $20, assuming your deductible was previously satisfied.

Order of Benefit Payment

Here are the rules for how to determine whether this plan is "primary" or "secondary" to any other plan. Remember that the "primary" plan pays first — and the "secondary" plan is any plan that may pay benefits after the primary plan. If satisfactory evidence is received that an individual contributed 50% or more of the monthly premium for other coverage, the benefits paid by the other coverage will **not** be considered in determining benefits under Plan 1. Plan 1 does **not** coordinate benefits with **individual** health care policies.

Medical

Medical Plan 1

Order of Benefit Payment

If...	And...	Then...
A person is covered by two medical plans	Only one plan has a Coordination of Benefits provision	The plan without the Coordination of Benefits provision is primary
A retiree covered under Plan 1 is also covered as an active employee under another employer plan	Both plans have a Coordination of Benefits Provision and retiree rule*	The other employer plan is primary
A retiree covered under Plan 1 is also covered as a dependent of a retiree under another employer plan	Both plans have a Coordination of Benefits Provision	Plan 1 is primary for the retiree
A retiree covered under Plan 2 is also covered as a dependent of a retiree under another employer plan	Both plans have a Coordination of Benefits Provision	Medicare is primary for the retiree and Plan 2 is secondary
A retiree covered under Plan 2 is also covered as the dependent of an active employee under another employer plan	Both plans have a Coordination of Benefits Provision	The other plan is primary for the retiree, Medicare is secondary, and Plan 2 is third
A retiree's spouse is covered as a dependent under Plan 1 and also as a retiree under another employer plan	Both plans have a Coordination of Benefits provision	The other employer plan is primary for the retired spouse

Chart continued on next page.

* See explanation on page 89.

Medical Plan 1

Chart continued from previous page.

If...	And...	Then...
A retiree's spouse is covered under Plan 1 and also as an active employee under another employer plan	Both plans have a Coordination of Benefits provision.	The other employer plan is primary for the retired spouse
A dependent child is covered by the plans of two parents who are not divorced or separated.	Both plans have a Coordination of Benefits provision and a birthday rule	The plan of the parent whose birthday falls first in the calendar year (birthday rule) is primary
	Both plans have a Coordination of Benefits provision but only one plan has a birthday rule	The father's plan is primary regardless of which plan has a birthday rule
A dependent child is covered by the plans of two parents who are divorced or separated	A court decree makes one parent financially responsible for health care	The plan of the parent who is financially responsible is primary
	There is no court decree and the parent with custody has not remarried	The plan of the parent with custody is primary
If a situation exists where the COB provision does not establish an order	Not applicable	The plan that has covered the person for the longer period of time is primary

* Retiree Rule — a rule that the plan covering an individual as an active employee is primary for the active employee and his/her dependent over a plan covering an individual as a retiree.

Medical

Medical Plan 1

Administration of Coordination of Benefits

In order to administer the Coordination of Benefits (COB) provision, Aetna has the right to release or obtain information, or to make or to recover any payments. Periodically, the Order of Benefit determination rules may change to reflect changes in the National Association of Insurance Commissioners (NAIC) model COB provision or other changes in regulations and laws.

Subrogation

In the event of any payment for services under the Navistar Retiree Health Benefit Program, Navistar or Aetna shall be subrogated to all rights of recovery of the retiree or dependent against any person or organization except against insurers on policies of insurance issued to and in the retiree's or dependent's name, or against a policy of insurance to which the retiree has contributed 50% or more of the premium. The retiree or dependent shall, at the request of Navistar or Aetna, execute and deliver such documents and papers as may be required and do whatever else is necessary to secure such rights.

Right of Recovery

The Insurance Company or the Company may recover excess payments made toward a covered expense at any time.

Whenever payments have been made by the Insurance Company or the Company with respect to covered services in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, the Insurance Company or the Company shall have the right to recover such payments to the extent of such excess, from among one or more of the following, as it shall determine:

- ✔ any person to, for, or with respect to whom, such payments were made,
- ✔ any insurance companies, and
- ✔ any other organizations.

The retiree, for himself/herself and on behalf of his/her dependents, must, upon request, execute and deliver such documents and papers as may be required, and do whatever else is necessary to secure such right to the Insurance Company or the Company.

Medical

Medical Plan 1

In the event that a benefit payment is made under Plan 1 or Plan 2 which is in excess of the benefit payment which should have been provided, the retiree shall be obligated to repay, in cash, the amount of such overpayment, upon appropriate notice of the amount to be repaid. If such repayment is not made within **60 days**, Navistar is authorized to deduct the amounts to be repaid from any amounts payable to the retiree by or on behalf of Navistar. The amount deducted from each benefit check shall be limited to $30.00 or the amount permitted by law, whichever is less. In any case where any overpayment cannot be recovered from the retiree, such overpayment may be recovered from the individual to whom or with respect to whom such overpayment was made. However, no repayment will be required unless notice is given to the retiree by Navistar or Aetna within **60 days** from the date Navistar or Aetna had knowledge of the overpayment, except that no such time limitation shall be applicable in cases of fraud or willful misrepresentation.

Coordination of Benefits: (Example)

Assume you participate as a retiree in your prior employer's (ABC Co.) plan, and as a retired dependent in Navistar Plan 1. Your ABC Co. plan is primary, and will pay benefits first. In this example, we will assume the following:

- ✔ $1,000 in covered expenses. All charges fall within R&C guidelines and are covered in full by both plans.
- ✔ The deductibles have been met. Both plans pay 80% toward covered expenses after the deductible has been met.
- ✔ Navistar Plan 1 is secondary and pays benefits after the ABC Co.

Example continued on next page.

Medical

Medical Plan 1

Example continued from previous page.

Here's how benefits would be figured separately by each plan.

ABC Co. (Primary)		Plan 1 (Secondary)	
Covered Expenses	$1,000	Covered Expenses	$1,000
ABC Co. share	x 80 %	Plan 1 share	x 80 %
Payable by ABC Co.	$ 800	Plan 1 Normal Payment	$ 800
Remaining Expense	$ 200	Remaining Expense (after ABC Co. payment)	$ 200
		Plan 1 COB payment	$ 200
		The normal Plan 1 benefit of $800 will coordinate with that of the ABC Co. so that the total payment from both plans will not exceed 100% of the total covered expense ($1,000).	

Here's how benefits would be coordinated and actually paid.

Covered Expense	$1,000
ABC Co. Payment	- 800
Remaining Expense	$ 200
Plan 1 Payment	$ 200

In coordinating benefits, Plan 1 will pay after the primary plan. Plan 1 will pay no more than its normal benefit payable toward the remaining expense, and payment from both plans will not exceed 100% of total covered expenses.

Medical Plan 2

Medical

Medical Plan 2

Summary

What Plan 2 Pays	Plan 2 Pays At This % After Out-of-Pocket Maximum
Inpatient Hospital Expenses – Semi-private Room & Board* – Physicians' and Surgeons' Services – Laboratory & X-ray tests – Hospice	100% of the difference between the Medicare-approved expense and the Medicare payment
Outpatient Medical Care – Diagnostic Laboratory & X-ray Tests – Surgery – Home Health Care – Hospice – Physician Office Visits, Other Than for Routine Care	100% of the difference between the Medicare-approved expense and the Medicare payment
Mental Health/Substance Abuse Care – Inpatient Psychiatric – Residential Treatment for Substance Abuse – Outpatient (including psychiatric and/or substance abuse treatment)	100% of the difference between the Medicare-approved expense and the Medicare payment

* In certain circumstances, Medicare covers private room charges when medically necessary.

Chart continued on next page.

Medical Plan 2

Chart continued from previous page.

What Plan 2 Pays	Plan 2 Pays At This % After Out-of-Pocket Maximum
Routine Health Care – Pap Tests	100% of the difference between the Medicare-approved expense and the Medicare payment One screening Pap test every three years
– Mammograms** (routine screening)	One screening mammogram every other year, if over age 65. Disabled persons under age 65 should contact Medicare regarding more frequent screenings. Must use designated centers listed on pages 67-69 if you reside in the ZIP codes specified.
– Routine Physical Exams	Not Covered
Other – Dental Care – Hearing Care – Vision Care	Not Covered

** If you live in certain geographic areas (based on ZIP code) you must use designated providers. See pages 67-69 for more information.

Chart continued on next page.

Medical Plan 2

Chart continued from previous page.

What The Program Pays	Retirees in Plan 1 and Plan 2 Pay This Amount	Coverage Information
Prescription Drug Charges		
– ValueRx Retail Network	Generic - $8 maximum/prescription per 30-day supply Brand-name - $18 maximum/prescription per 30-day supply	Copayment is per prescription per 30-day supply. 100- and 200-unit drugs that are listed on page 131 are covered in a 90-day supply with a 3-month copayment ($24 or $54)
– Express Pharmacy Mail Order Plan	$7 maximum/prescription per 30-day supply	Copayment is per prescription per 30-day supply; maximum 90-day supply at one time For example, a 90-day supply of medication would come to $21 per prescription per covered person

Note: Prescription drugs are not covered under Medicare.

Medical Plan 2

Medical Plan 2 is a Medicare supplement plan that helps pay for expenses covered by Medicare, but not paid in full by the government program. Medicare will pay only a portion of "Medicare-approved" or "Medicare-covered" expenses. You are responsible for paying the rest. That's where Plan 2 can help. **Plan 2 will assist you by placing a limit on the costs you have to pay each year toward Medicare-approved expenses.** This is especially important if you have a catastrophic illness or injury.

Retirees who are eligible to purchase Medicare Part A and Medicare Part B will be covered under Plan 2, and will be expected to purchase both parts of Medicare. **If you choose not to purchase Part B, you will have to pay for whatever Medicare would have covered under that part of the program.** In addition, none of those charges would be considered Medicare-approved. They would not count toward your calendar year Out-of-Pocket Maximum, and would not be reimbursable by Plan 2.

Retirees and their dependents, who are eligible for Medicare, but who are required to pay for Part A of Medicare because of ineligibility for Social Security Benefits or other reasons, are encouraged to enroll in Part A and pay the required Medicare Part A premium ($221 per month in 1993) since Plan 2 coverage will calculate benefits payable as if Medicare Part A coverage was in effect.

Foreign service retirees (Third Country Nationals), who repatriate (return to home country) and are covered by National Health Care in their home country, and are age 65 or over, will be eligible for coverage under Plan 2 by paying the required monthly premium for Plan 2.

Medical Plan 2

For travel outside the United States or its territories, if Medicare doesn't cover the expense, Plan 2 won't cover it either, except for prescription drug expenses or for emergency medical services incurred by a U.S. resident while temporarily traveling (less than 6 months) outside the United States or its territories. This coverage does not apply to travel that **exceeds 6 months.** Emergency medical services result from a sudden and unexpected onset or increase in symptoms which require immediate medical care which the patient seeks promptly after the onset or increase in symptoms, or as soon thereafter as practical. Conditions such as colds, flu, migraine headaches, bladder infections, gastritis, etc. are generally not covered medical emergencies. Emergency treatment of accidental injuries is covered if the treatment is received or commenced **within 24 hours** following the accident. Covered services rendered outside the U.S. or its territories must be submitted to Medicare for consideration. Emergency medical services are subject to all other Plan restrictions described in this book.

Retirees who are not eligible to purchase Medicare Part A and Medicare Part B will be covered under Plan 1 until they are eligible. Then they will be covered under Plan 2.

Summary of Benefits: What You Pay

This chart provides an overview of what you pay toward benefits when you participate in both Parts A and B of Medicare, and Plan 2. As you can see, you pay a monthly premium to receive coverage under Medical Plan 2, and a monthly premium to receive medical benefits under Medicare Part B. You share in the cost of medical benefits until you reach an annual Out-of-Pocket Maximum. Then Plan 2 will pay 100% of the difference between the Medicare-approved amount and the Medicare payment for the rest of that calendar year.

Medical

Medical Plan 2

What You Pay	How Much You Pay
Monthly Premiums* The amount you pay each month for yourself and each covered adult to participate in Medical Plan 2.	$34* per month per covered adult.
Part B Medicare Premium The amount you pay each month to receive medical benefits under Medicare Part B.	Amount (determined by Medicare each year) paid monthly by retiree/ surviving spouse. Usually deducted from Social Security check.
Annual Out-of-Pocket Maximum* The most each covered individual will pay toward Medicare-approved expenses each calendar year. Once your share of covered expenses exceeds the Out-of-Pocket Maximum, Plan 2 will pay 100% of the difference between the Medicare-approved expenses and the Medicare payment.	$200* per calendar year per covered individual.

* Premiums and Out-of-Pocket Maximums may change in order to keep up with increases or decreases in the cost of benefits, under limited circumstances described in the **Shy Settlement Agreement.**

Note:
Prescription drug copayments **do not count** toward the annual Out-of-Pocket Maximum.

Medical

Medical Plan 2

What Does The Plan 2 Out-of-Pocket Maximum Include?

Since Plan 2 doesn't begin paying benefits until you've met your annual Out-of-Pocket Maximum, it's important to understand the type of expenses it includes. Here is a checklist of some of the common costs the Medicare program won't pay — and which of those costs will count toward meeting your Out-of-Pocket Maximum.

- ✔ Medicare Part A hospital deductible? ..... Yes
- ✔ Medicare Part A hospital daily coinsurance? ..... Yes
- ✔ Hospital care beyond Medicare's 90-day limit? ..... No
  (except that Medicare has a 60-day lifetime reserve provision for hospital confinements.)
- ✔ Skilled nursing facility coinsurance? ..... Yes
- ✔ Skilled nursing facility care beyond Medicare's limits? ... No
- ✔ Medicare Part B annual deductible? ..... Yes
- ✔ Medicare Part B coinsurance? ..... Yes
- ✔ Charges in excess of Medicare-approved amounts? ..... No
- ✔ Medicare blood deductibles? ..... Yes
- ✔ Prescription drug copayments? ..... No

You may use this list in evaluating other health insurance coverage you may be considering, as well.

Medical

Medical Plan 2

Summary of Benefits: What Plan 2 Pays

Plan 2, and Medicare, will only cover services and supplies that are medically necessary. Medicare will pay benefits first. The payment under Plan 2 is limited to the Medicare-approved amount for providing a service or supply.

The following charts summarize Medicare benefits in effect as of January 1, 1993. These are intended to provide you with general information on Medicare coverage. Your coverage under Plan 2 is completely dependent on how Medicare actually handles your claim. **If Medicare doesn't cover an expense, Plan 2 won't cover it either, except for prescription drug expenses.** Prescription drug expenses are always subject to the copayment amounts shown. For a more complete listing of covered expenses, refer to *"Your Medicare Handbook."* If you don't have this booklet, call **1-800-772-1213** to request it.

Medical

Medical Plan 2

Medicare Part A Covered Expenses

Covered Expense Part A Hospital Insurance	Medicare Pays First After Required Deductibles	Plan 2 Pays After You've Met The Out-Of-Pocket Maximum	Coverage Information
Hospital Expenses – Semi-private Room and Miscellaneous Expenses* – General Nursing – Miscellaneous Hospital Services and Supplies	100% up to 60 days per benefit period. You must pay a portion of the charge for days 61-90. You may have additional medical coverage for days 91-150, depending on whether you have used part or all of your 60 reserve days. You must pay a portion of the charge for lifetime reserve days (91-150).	100% of difference between Medicare-approved expenses and Medicare payment	No coverage from Medicare or Plan 2 beyond 90 or 150 days per benefit period (whichever applies)

* In certain circumstances, Medicare covers private room charges when medically necessary.

Chart continued on next page.

Medical Plan 2

Chart continued from previous page.

Covered Expense Part A Hospital Insurance	Medicare Pays First After Required Deductibles	Plan 2 Pays After You've Met The Out-Of-Pocket Maximum	Coverage Information
Skilled Nursing Facility	100% first 20 days, copay-ment next 80 days per benefit period	100% of the difference between Medicare-approved expense and Medicare payment during 100 days per benefit period	Must have been in a hospital at least 3 days and enter a Medicare-approved facility within 30 days after hospital discharge No coverage, Medicare or Plan 2, beyond 100 days per benefit period No coverage for Custodial Care
Home Health Care	100% part-time or intermittent skilled nursing care; 80% durable equipment	100% of the difference between Medicare-approved expense and Medicare payment	Neither Plan pays toward homemaker services (e.g., meals delivered to the home)

Chart continued on next page.

Medical

Medical Plan 2

Chart continued from previous page.

Covered Expense Part A Hospital Insurance	Medicare Pays First After Required Deductibles	Plan 2 Pays After You've Met The Out-Of-Pocket Maximum	Coverage Information
Hospice Care	100%, except limitations noted by Medicare	100% of the difference between Medicare-approved expense and Medicare payment	Medicare pays a portion of covered charges toward Outpatient drugs and Inpatient respite care
Blood	100%, after first 3 pints per calendar year	100% of the difference between Medicare-approved expense and Medicare payment	
Mental and Nervous Disorders – Inpatient Psychiatric Hospital (Part A)	**100% up to 190 days, lifetime	100% of the difference between Medicare-approved expense and Medicare payment	Must be confined in a Medicare-approved psychiatric hospital

** If you are a patient in a psychiatric hospital when first eligible for Medicare, there is a special rule that applies. Social Security can give you more information.

Medical

Medical Plan 2

Medicare Part B Covered Expenses

Covered Expense Part B Medical Insurance	Medicare Pays First, Up To Medicare-Approved Amount After You've Paid Deductible Required	Plan 2 Pays After You've Met The Out-Of-Pocket Maximum	Coverage Information
Medical Care – Doctor's Services – Diagnostic Tests – Ambulance – Physical and Speech Therapy – Diagnostic Mammography	80%	100% of the difference between Medicare-approved expense and Medicare payment	
Clinical Laboratory Services – Blood, Urine tests – Biopsies	100%	100% of the difference between Medicare-approved expense and Medicare payment	

Chart continued on next page.

Medical

Medical Plan 2

Chart continued from previous page.

Covered Expense Part B Medical Insurance	Medicare Pays First, Up To Medicare-Approved Amount After You've Paid Deductible Required	Plan 2 Pays After You've Met The Out-Of-Pocket Maximum	Coverage Information
Home Health Care	100% part-time or intermittent skilled care; 80% durable equipment	100% of the difference between Medicare-approved expense and Medicare payment	No coverage for certain services, such as homemaker services, meals delivered, or 24-hour nursing care
Outpatient Hospital Care – Diagnosis and Treatment of Illness or Injury	80%	100% of the difference between Medicare-approved expense and Medicare payment	

Chart continued on next page.

Medical Plan 2

Chart continued from previous page.

Covered Expense Part B Medical Insurance	Medicare Pays First, Up To Medicare-Approved Amount After You've Paid Deductible Required	Plan 2 Pays After You've Met The Out-Of-Pocket Maximum	Coverage Information
Blood	80%, starting with 4th pint	100% of the difference between Medicare-approved expense and Medicare payment	No coverage first three pints of blood
Mental and Nervous Disorders – Outpatient Treatment	50% of total approved charges	100% of the difference between Medicare-approved expense and Medicare payment	

Chart continued on next page.

Medical

Medical Plan 2

Chart continued from previous page.

Covered Expense Part B Medical Insurance	Medicare Pays First, Up To Medicare-Approved Amount After You've Paid Deductible Required	Plan 2 Pays After You've Met The Out-Of-Pocket Maximum	Coverage Information
Routine Health Care			
– Pap Tests	80%	100% of the difference between Medicare-approved expense and Medicare payment	One screening Pap test every 3 years; as needed when symptoms present
– Mammograms, (Screening) **Note:** If Medicare denies benefits because of frequency, Plan 2 will pay at 100%, with no deductible, as long as the Plan 2 frequency limit of two years was met and a designated center was used	80%	100% of the difference between Medicare-approved expense and Medicare payment	One screening mammogram every other year, age 65+. Disabled persons under age 65 should contact Medicare regarding more frequent screenings. Must use designated centers listed on pages 67-69 if you reside in the ZIP codes specified
– Routine Physical exam	No Coverage	No Coverage	

Medical

Medical Plan 2

Prescription Drug Benefits

What The Program Pays	Retirees in Plan 1 and Plan 2 Pay This Amount	Coverage Information
Prescription Drug Charges		
– ValueRx Retail Network	Generic - $8 maximum/prescription per 30-day supply Brand name - $18 maximum/prescription per 30-day supply	Copayment is per prescription per 30-day supply. 100- and 200-unit drugs that are listed on page 131 are covered in a 90-day supply with a 3-month copayment ($24 or $54)
– Express Pharmacy Mail Order Plan	$7 maximum/prescription per 30-day supply	Copayment is per prescription per 30-day supply; maximum 90-day supply at one time For example, a 90-day supply of medication would come to $21 per prescription per covered person

Note: Prescription drugs are not covered under Medicare.

Medical

Medical Plan 2

Definition of Some Important Terms

Medically necessary: A service or supply that is necessary for the diagnosis, care or treatment of the physical or mental condition involved. Refer to the "Glossary" for a complete definition.

Medicare-approved (covered) expenses: Medicare covers only certain expenses and pays only part of those expenses. This is called the "Medicare-approved" amount. It is the lower of the actual charge made by a physician or provider of the service, or the fee schedule amount applied to it in a specific geographic area.

Note:
The Program is designed to track Medicare's ongoing scope and level of benefits and its eligibility standards, as each of these features is specified under current law. An example of such a feature is the Program's coverage for the automatic increase in the Medicare Part A inpatient hospitalization deductible under current law.

Future legislation may change Medicare. If the Medicare changes are minor, the Company has the ability to change the Program accordingly, without any effect on overall benefits available from the Program. If Medicare makes major changes (such as an increase in the Medicare Part B annual deductible), the Health Benefit Plan Committee will redesign the benefits as long as the Company's liability is not increased.

Medical Plan 2

An Example of How Plan 2 Expenses Are Shared

Here's What Happened to Jim:

Here's an example of how Jim, Plan 2 and Medicare would share the costs of medical care.

Let's assume:

- ✔ Jim is hospitalized for 80 days following a serious injury or illness
- ✔ Medicare-approved expenses total $50,000
- ✔ Jim has not yet met his Plan 2 Out-of-Pocket maximum for the year

* Medicare Part A payment amounts are based on 1993 rates.

Jim's total amount of Medicare-approved expenses	$50,000
Medicare Part A payment to hospital	-45,944
Jim's share of the Medicare eligible expenses. This includes the $676 Medicare Part A deductible and Medicare's coinsurance charge of $169 per day for days 61-80.	$ 4,056
Jim's Out-of-Pocket Maximum for Plan 2	- 200
Amount paid by Medical Plan 2	$ 3,856
Total Cost Medicare Pays:	$45,944
Plan 2 Pays:	$ 3,856
Jim Pays:	$ 200

For more information regarding Medicare and Medicare eligibility, see the section on "Medicare" in the General Information part of this booklet.

Medical

Medical Plan 2

Health Maintenance Organizations (HMOs)

These plans generally offer medical and prescription drug coverage, and some offer vision care and hearing care services. To the extent that the HMO does not provide drug benefits substantially equivalent to the Company policy, arrangements will be made to provide those benefits through the Company Program. HMO coverage also offers physician's office visits and preventive care.

Navistar will pay the premium for the Health Maintenance Organization (HMO) coverage up to the cost the Company would have incurred if the retiree or surviving spouse were covered by the Company Program. HMO premiums in excess of the cost of the Company Program are the responsibility of the retiree or surviving spouse, and are payable to the Company.

Medicare-approved Expenses

Medicare and Plan 2 will only reimburse you for covered expenses up to the **Medicare-approved amount.** You are responsible for any additional charges from a physician or supplier to the extent that you are legally obligated to pay them.

To minimize your out-of-pocket costs, you may want to choose a doctor who "accepts assignment." A doctor who accepts assignment agrees to take only the Medicare-approved amount as full payment for his/her services. The names and addresses of these providers are listed in the Medicare-Participating Physician/Supplier Directory. Contact your Social Security Office for more information.

While a doctor who does not accept assignment will charge you for the full cost of his/her services, there is still a limit on how much that charge can be. The 1990 Budget Reconciliation Act allows Medicare to limit the amount above the Medicare-approved expense that a doctor may balance-bill a patient. In addition, a doctor who does not accept assignment must provide you with a written estimate of what the fee will be for elective surgery procedures of $500 or more.

Another important point. Some doctors who do not accept assignment on all claims may choose to accept assignment on some claims. Ask your doctor to be sure.

Medical Plan 2

Here's an example of what Medicare assignment can mean to your out-of-pocket costs. Assume Joe is a retiree who is Medicare-eligible and covered under Plan 2. He has met any required Medicare Part B deductibles, and has met his calendar year Out-of-Pocket Maximum of $200. Here's what happens if Joe's doctor accepts assignment — and if he doesn't.

	Doctor Accepts Assignment	Doctor Does NOT Accept Assignment
Doctor's Actual Charge	$ 600	$ 600
Medicare-Approved Amount	480	480
Medicare Pays	384	384
Plan 2 Pays	96	96
Joe Pays	$ 0	$ 120

If Joe's physician does not accept assignment, Joe has to pay the $120 difference between the Medicare-approved amount and the actual charge out of his own pocket. In addition, if Joe had not already met his annual Out-of-Pocket Maximum under Plan 2, the $120 would not have applied toward meeting the Out-of-Pocket Maximum.

Medical

Medical Plan 2

Important Points About Plan 2

The following are important points to remember about Plan 2.

1. Only your share of Medicare-approved expenses are covered under Plan 2.
2. Any Medicare-non-approved expenses must be fully paid by you, to the extent that you are legally obligated to pay them. If you go to a provider who accepts Medicare assignment, that provider cannot legally bill you for anything over the Medicare-approved amount. So, by selecting a provider who accepts Medicare assignment, you can limit the amount you will have to pay for your care.
3. Each year, you will need to meet a new Out-of-Pocket Maximum of Medicare-approved expenses.
4. You must enroll for both Medicare Part A and Medicare Part B. If you don't, you will be responsible for all expenses Medicare would have paid for, if you had the coverage. In addition, the Plan 2 Out-of-Pocket Maximum does not apply to these amounts.
5. The Program is designed to track Medicare's ongoing scope and level of benefits and its eligibility standards, as each of these features is specified under current law. An example of such a feature is the Program's coverage for the automatic increase in the Medicare Part A inpatient hospitalization deductible under current law.

   Future legislation may change Medicare. If the Medicare changes are minor, the Company has the ability to change the Program accordingly, without any effect on overall benefits available from the Program. If Medicare makes major changes (such as an increase in the Medicare Part B annual deductible), the Health Benefit Plan Committee will redesign the benefits as long as the Company's liability is not increased.

Medical

Medical Plan 2

Covered Medical Expenses

Medical Plan 2 is a Medicare supplement plan, designed to help you pay for expenses that are covered by Medicare, but not paid in full.

Plan 2 limits covered expenses to those charges which are eligible for reimbursement under the Medicare program. Medicare Part A (Hospital Insurance) provides coverage within these **four** categories:

- ✔ Inpatient Hospital Care
- ✔ Skilled Nursing Facility Care
- ✔ Home Health Care
- ✔ Hospice Care

Medicare Part B (Medical Insurance) covers expenses including:

- ✔ Doctors' Services
- ✔ Emergency Room Care
- ✔ Ambulance Services
- ✔ Clinical Laboratory Tests

Medical

Medical Plan 2

Refer to "Your Medicare Handbook" for a complete listing of covered expenses. Plan 2 covers the difference between the Medicare-approved or covered amount, and the amount Medicare paid. However, you must first meet the annual Out-of-Pocket Maximum for Plan 2.

Q: Will Plan 2 provide coverage for Prescription Drug expenses, even though Medicare doesn't?

A: Yes. Plan 2 provides Prescription Drug coverage through both a retail pharmacy plan and a mail order pharmacy plan. Refer to the "Prescription Drug Plan" section for more information.

Q: What about coverage for oral surgery?

A: Medicare does not pay for surgical procedures involving the teeth or structures directly supporting the teeth. It does share the costs in cases where the medical problem is more extensive than the teeth or structures directly supporting them. Call the Social Security office for more information on covered expenses.

Q: What about expenses for Emergency medical care?

A: Medicare provides coverage for expenses relating to Emergency Care for a sudden and unexpected change in a person's physical or mental condition severe enough to require immediate medical attention. "Covered expenses" include ambulance service and outpatient hospital services, including services in an Emergency room or Outpatient clinic.

Medical

Medical Plan 2

Expenses Not Covered

Any expense, other than prescription drugs, which is **not** covered by Medicare is **not** covered by Plan 2.

Here is a brief listing of some of the expenses **not** covered by the Medicare program. For complete information, refer to "Your Medicare Handbook."

These expenses are not covered by Medicare or by Plan 2

1. **Custodial Care**
   Excludes coverage for services intended primarily to help with activities of daily living or meeting personal needs and which could be provided safely and reasonably by people without professional training or skill.
2. **Excess Charges**
   The difference between the Medicare-approved amount for a covered service and the actual charge for providing it.
3. **Foreign Medical Services**
   Charges for care received outside the United States and its territories, except for care provided in certain limited circumstances within Canada and Mexico.
4. **Government Programs**
   Any charges for services paid by another government program.
5. **Home Health**
   Charges for services for:
   - ✔ homemaker services,
   - ✔ drugs or meals delivered to the home,
   - ✔ services performed by immediate relatives or members of the household.
6. **Inpatient Hospital**
   Excludes coverage for hospitalization beyond **90 days** during a benefit period, except for the **60-day** lifetime reserve.
7. **Medically Necessary**
   Charges for services not medically necessary for the diagnosis, care or treatment of the physical or mental condition involved.

Medical Plan 2

8. **Nursing Home Care**

   Charges for Nursing Home Care, other than skilled nursing care provided in a Medicare-approved skilled nursing facility up to the daily limits applied during a benefit period.

9. **Personal Convenience**

   Charges incurred for personal convenience items or personal comfort, including:

   - ✔ telephones and/or TV in a room,
   - ✔ private hospital room (unless medically necessary), and
   - ✔ private duty nursing services.

10. **Prescription Drugs**

    The general exclusions listed above, and the "Expenses Not Covered" in the Prescription Drug Plan section of this book, apply to the Prescription Drug Plan.

11. **Vision/Dental/Hearing**

    Charges formerly paid under the Vision, Dental and Hearing Plans are no longer covered. The Company intends to establish Vision/Dental/Hearing discount programs that will be made available to retirees.

Medical

Medical Plan 2

How Plan 2 Benefits Are Coordinated

Plan 2 maintains benefits with other group coverage that you may have. This means that first the Plan 2 benefit is figured as if the other plan wasn't paying benefits. That benefit is compared to the benefit actually paid by the other plan. If the other plan payment is greater than the Plan 2 benefit, no benefits would be payable from Plan 2. If the other plan payment is less than the Plan 2 benefit, the difference will be payable by Plan 2.

In establishing an order for benefit payment, one plan will pay before the other plan. See the "Order of Benefit Payment" section on the following page for more information.

If you are Medicare-eligible, Plan 2 is secondary to Medicare. Claims should be submitted to Medicare before being submitted to Navistar.

For Medicare-eligible retirees, surviving spouses and covered dependents, Medicare will be the "primary plan" of coverage. Plan 2 will be the "secondary plan," and will pay the difference between the Medicare-approved amount and the amount Medicare paid. If satisfactory evidence is received that an individual contributed 50% or more of the monthly premium for other coverage, the benefits paid by the other coverage will **not** be considered in determining benefits under this plan.

Medical Plan 2 will **not** coordinate benefits with any **individual** insurance plan. Examples include "Medigap" policies, as well as:

- ✔ Policies you may have converted to individual coverage when eligible,
- ✔ Nursing home or Long-Term Care policies, and
- ✔ Hospital Indemnity policies, which provide cash amounts for specified days of Inpatient hospital care.

Medical

Medical Plan 2

Order of Benefit Payment

Here are the rules for how to determine whether this plan is "primary" or "secondary" to any other plan. Remember that the "primary" plan pays benefits first. The "secondary" plan is any plan that pays benefits after the primary plan.

If...	And...	Then...
A person is covered by two medical plans	Only one plan has a Coordination of Benefits provision	The plan without the Coordination of Benefits provision is primary
A retiree or dependent who is Medicare-eligible is also covered under Plan 2	Both plans have a Coordination of Benefits Provision and retiree rule*	Medicare is primary
A retiree's spouse is covered under Plan 2 and also as a retiree under another employer plan	Both plans have a Coordination of Benefits Provision	Medicare is primary The other employer plan is secondary for the retired spouse

* Retiree Rule: a rule that the plan covering an individual as an active employee is primary for the active employee and his/her dependent over a plan covering an individual as a retiree.

Chart continued on next page.

Medical Plan 2

Chart continued from previous page.

If...	And...	Then...
A dependent child is covered by the plans of two parents who are not divorced or separated	Both plans have a Coordination of Benefits provision and a birthday rule	The plan of the parent whose birthday falls first in the calendar year (birthday rule) is primary
	Both plans have a Coordination of Benefits provision but only one plan has a birthday rule	The father's plan is primary regardless of which plan has a birthday rule
A dependent child is covered by the plans of two parents who are divorced or separated	A court decree makes one parent financially responsible for health care	The plan of the parent who is financially responsible is primary
	There is no court decree and the parent with custody has not remarried	The plan of the parent with custody is primary
If a situation exists where the COB provision does not establish an order	Not applicable	The plan that has covered the person for the longer period of time is primary

Medical

Medical Plan 2

Administration of Coordination of Benefits

In order to administer the Coordination of Benefits (COB) provision, Aetna has the right to release or obtain information, or to make or to recover any payments. Periodically, the Order of Benefit determination rules may change to reflect changes in the National Association of Insurance Commissioners (NAIC) model COB provision or other changes in regulations and laws.

Subrogation

In the event of any payment for services under the Navistar Retiree Health Benefit Program, Navistar or Aetna shall be subrogated to all rights of recovery of the retiree or dependent against any person or organization except against insurers on policies of insurance issued to and in the retiree's or dependent's name, or against a policy of insurance to which the retiree has contributed 50% or more of the premium. The retiree or dependent shall, at the request of Navistar or Aetna, execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights.

Right of Recovery

Whenever payments have been made by the Insurance Company or the Company with respect to covered services in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, the Insurance Company or the Company shall have the right to recover such payments to the extent of such excess, from among one or more of the following, as it shall determine:

- ✔ any person to, for, or with respect to whom, such payments were made,
- ✔ any insurance companies, and
- ✔ any other organizations.

The retiree, for himself/herself and on behalf of his/her dependents, must, upon request, execute and deliver such documents and papers as may be required, and do whatever else is necessary to secure such right to the Insurance Company or the Company.

Medical Plan 2

The Insurance Company or the Company may recover excess payments made toward a covered expense at any time

In the event that a benefit payment is made under Plan 1 or Plan 2 which is in excess of the benefit payment which should have been provided, the retiree shall be obligated to repay, in cash, the amount of such overpayment, upon appropriate notice of the amount to be repaid. If such repayment is not made within **60 days**, Navistar is authorized to deduct the amounts to be repaid from any amounts payable to the retiree by or on behalf of Navistar. The amount deducted from each benefit check shall be limited to $30.00 or the amount permitted by law, whichever is less. In any case where any overpayment cannot be recovered from the retiree, such overpayment may be recovered from the individual to whom or with respect to whom such overpayment was made. However, no repayment will be required unless notice is given to the retiree by Navistar or Aetna within **60 days** from the date Navistar or Aetna had knowledge of the overpayment, except that no such time limitation shall be applicable in cases of fraud or willful misrepresentation.

Medical

Medical Plan 2

How Covered Expenses Are Shared

Here's What Happened to Bud:

Here's an example of how you, Plan 2 and Medicare share covered expenses for your Medical care. Bud is covered under Plan 2, and he's incurred the following expenses in March and May of this year. Here's how the expenses would be treated by Medicare and Plan 2.

March: Bud had Outpatient physician expenses of $150.

May: Bud had Outpatient surgical expenses of $500.

Medicare (Primary Plan)		Plan 2 (Secondary)	
March:			
Physician Expenses	$ 150	Physician Expenses (Medicare approved)	$ 150
Part B Deductible	−100	Medicare Part B Payment	−40
Remaining Expenses	$ 50		
Part B Coinsurance	x 80 %	Expense applied to Bud's Out-of-Pocket Maximum	$ 110
Part B Pays	$ 40		
May:			
Outpatient Surgery	$ 500	Outpatient Surgery	$ 500
Medicare Part B Payment	x 80 %	Medicare Part B Payment	− 400
(Bud had met his deductible)	$ − 400	Expense applied to Bud's Out-of-Pocket Maximum	$ 100
Bud's share of the Medicare approved expense	$ 100	Out-of-Pocket Expense for March charges	+ 110
			$ 210
		Bud's annual Out-of-Pocket Maximum	− 200
		Paid by Plan 2	$ 10

Since Bud has met his annual Out-of-Pocket Maximum in May, Plan 2 will pay 100% of Bud's Medicare-approved expenses for the remainder of the calendar year.

Medical

Medical Plan 2

Is Plan 2 Right For Me?

Selecting Health Insurance is an important decision. Before you decide on coverage under Plan 2, evaluate your alternatives. There are a number of resources available that can provide the information you'll need to make an informed choice. These include:

- ✔ your State Insurance Dept.,
- ✔ the U.S. Dept. of Health and Human Services **(1-800-772-1213)**, which makes "The Medicare Handbook," available, and
- ✔ The National Council for Aging **(202-479-1200)** and similar organizations informed about retiree issues.

When evaluating your choices, think about:

1. What medical expenses can you anticipate?
   List your ongoing expenses, such as prescription medication, as well as expenses you might be incurring for surgery or other major medical care.
2. How much can you afford to pay?
   In most cases, the more coverage a plan provides, the higher the cost for coverage.
3. What services are covered?
   Comprehensive plans coordinate coverage for hospital, surgical and physician care. Some plans cover only one or two areas of health care, for example, benefits for a specific disease or hospital-only coverage.
4. Are prescription drugs covered?
   This can be a major expense, and many plans don't offer this coverage. For example, Navistar Retiree Plan 2 offers local pharmacy and mail order coverage.
5. Do you understand the laws regulating Medigap policies?
   You have six **(6) months after your 65th birthday** to buy a Medigap policy without being rejected for pre-existing conditions. All policies are guaranteed renewable. But check the brochure describing the policy carefully.

Medical

Medical Plan 2

Follow these tips suggested in "The Medicare Handbook."

1. Shop carefully before you buy.
2. Don't buy more policies than you need.
3. Be aware of maximum benefits.
4. Read the outline of coverage carefully.
5. Take time to decide!

For information about what Medicare pays and does not pay, or types of private health insurance to supplement Medicare, and for hints on shopping for private health insurance, write for a free copy of the "Guide to Health Insurance for People With Medicare." The address is: Consumer Information Center, Dept. 59, Pueblo, CO 81009.

Prescription Drug Plan

Medical

Prescription Drug Plan

Plan 1 And Plan 2

The Prescription Drug Plan provides coverage for you and your eligible dependents for the Reasonable and Customary charges for prescription drugs or refills. There are two plans available:

- ✔ a Retail Prescription Drug Plan, and
- ✔ a Mail Order Prescription Plan.

Benefits are paid for a drug prescribed by a physician to treat a disease, injury, obesity or pregnancy. There is a copayment required for each prescription you request. Prescription drug copayments do not apply toward the annual Plan 1 copayment or to the annual Plan 2 Out-of-Pocket Maximum.

The Retail Prescription Drug Plan: ValueRx

Through the ValueRx Retail Prescription Drug Plan, there are two types of pharmacies you can use:

1. **Participating Pharmacy**
   This is a pharmacy that has a written agreement with ValueRx to provide prescription drug service.
2. **Non-Participating Pharmacy**
   This is a pharmacy that has no agreement with the ValueRx Plan.

Depending on the type of pharmacy you use, your benefits and claim filing procedures will be different.

ValueRx
1-800-347-8777
9:00 a.m. to 10:00 p.m., (Eastern Standard Time), Monday-Friday
9:00 a.m. to 5:00 p.m., (Eastern Standard Time), Saturday
10:00 a.m. to 4:00 p.m., (Eastern Standard Time), Sunday

Prescription Drug Plan

If You Reside In A Participating Pharmacy Area

A participating pharmacy area is a geographic area where there is a pharmacy within a **three (3) mile radius** of the retiree's home, that has contracted with ValueRx. If there is no contracted pharmacy within the **three (3) mile radius**, ValueRx will contract with the nearest pharmacy to the retiree's home.

Here's how it works if you purchase prescription drugs within a participating area:

From A Participating Pharmacy	**From A Non-Participating Pharmacy**
Pay copayment per prescription per 30-day supply $8 generic $18 any brand-name **Note:** If the charge for the drug is less than the copayment, you pay only the actual drug charge. Show your ID card to pharmacist Complete and sign the claim forms the pharmacist gives you The pharmacy files all claims	Pay the pharmacy's full charge for prescription drug or refill Ask the pharmacist to complete a claim form for the ValueRx Plan Send the claim form, with your receipt attached to your program. (See "A Non-Participating Pharmacy Area" for details) The Program will reimburse you for 75% of the cost after the required copayment

Medical

Prescription Drug Plan

A Non-Participating Pharmacy Area (If you do not reside in a ValueRx network area)

A Non-Participating Pharmacy Area is one in which there is no pharmacy that has contracted with ValueRx. Since there is no agreement for services to Navistar retirees, you must pay the pharmacy's full cost for each prescription, and submit a request for reimbursement to ValueRx. Follow these steps:

1. Pay the pharmacy's full charge for each prescription drug or refill.
2. Ask the pharmacist to complete a ValueRx prescription drug claim form.
3. Send the claim form, with your receipt attached, to ValueRx at:

   ValueRx Pharmacy, Inc.
   Attn: Member Reimbursement
   22255 Greenfield, Suite 550
   Southfield, MI 48075
4. The Program will reimburse you 100% of the cost, after the required copayment.

Covered Drugs

The Program includes coverage for:

- ✔ all prescribed legend drugs
- ✔ certain prescribed non-legend drugs

Legend drugs are those required by the Federal Food, Drug and Cosmetic Act to bear on their labels the legend: "Caution: Federal Law prohibits dispensing without a prescription."

Non-Legend drugs include Adrenalin, Aveeno, Isuprel (inhalant), Peritrate, and Acidolate. Injectables such as Insulin, Adrenalin, Mercuhydrin, and Thiomerin, are also covered.

> Note:
> Charges for more than a **30-day** supply of drugs purchased at one time through a ValueRx Pharmacy are not covered, except for the drugs listed on the next page, which may be purchased in 100- or 200-unit doses (tablet or capsule) subject to the monthly copayment requirement. For example, if you purchase a **90-day** supply, you must pay a $24 copayment for generic drugs or a $54 copayment for brand name drugs.

Medical

Prescription Drug Plan

100-Unit Drugs		
Acebutolol	Gemfibrosil	Phenformin
Acetazolamide	Glipizide	Pindolol
Acetohexamide	Glyburide	Polythiazide
Albuterol	Hydralazine	Potassium Chloride Liquid
Allopurinol	Hydrochlorothiazide	Potassium Chloride Tablets
Amiloride	Hydrochlorothiazide/ Spironolactone	Potassium Gluconates
Amiloride HCL Hydrochlorothiazide	Hydrochlorothiazide/ Triamterene	Probenecid
Atenolol	Indomethacin	Probucol
Bendroflumethiazide	Isosorbide	Procainamide
Benzthiazide	Labetalol	Propranolol Hydrochloride
Bumetanide	Liotrix	Prazosin Hydrochloride
Captopril	Lisinopril	Quinidine Sulfate
Chlorothiazide	Metaproterenol	Reserpine
Chlorpropamide	Methazolamide	Spironolactone
Chlorthalidone	Methyclothiazide	Sulindac
Clonidine	Methyldopa	Terbutaline
Clonidine-Hydrochlorides	Metolazone	Theophylline
Conjugated Estrogens U.S.P.	Metoprolol	Timolol Drops
Digitoxin	Minoxidil	Timolol Maleate
Digoxin	Nadolol	Tolazamide
Diltiazem	Naproxen	Tolbutamide
Dipyridamole	Nifedipine	Triamterene
Disopyramide	Nitroglycerin	Trichlormethiazide
Enalapril	Papaverine	Verapamil
Furosemide		

200-Unit Drugs		
Isoniazid	Liothyronine	Phenytoin (Diphenylhydantoin)
Natural and Synthetic Thyroid	Para-Aminosalicylic Acid	Propylthiouracil
Levothyroxine	Primidone	Thyroglobulin

Medical

Prescription Drug Plan

Prior Authorization Program

Many prescriptions can be potentially harmful when not used according to the drug manufacturer's guidelines for appropriateness. ValueRx will check with your physician if these situations occur with the following medications:

- ✔ Nicotine Patches
- ✔ Nicorette Gum
- ✔ Erythropoletin
- ✔ Growth Hormone
- ✔ Tretinoin (Retin-A)

New medications may be added to this list as they are released onto the market, or new safety information is made available for drugs already released on the market.

Under the Prior Authorization program, when ValueRx receives your claim for one of the medications listed above, a pharmacist will call your physician to verify the need to prescribe the medication differently than the manufacturer has recommended. Based upon this discussion, your prescription will be dispensed, exchanged, adjusted, or will not be dispensed.

It is important to note that nicotine replacement products such as the Nicotine Patch and Nicorette Gum are meant to be used with a smoking cessation program. Smoking cessation courses are **not** covered by the Program.

Preferred Quality Drug List (Voluntary Formulary)

Your physician will receive a list of medications for common ailments which have attained a "preferred" status from ValueRx's committee of physician specialists. These medications have been judged to be of superior quality, and often are less costly. You and your physician, however, still have the freedom to choose the medication that will work best for you.

Medical

Prescription Drug Plan

Mandatory Generic Substitution Program

If a generic substitute is available for a medication, you will be required to receive the generic, or pay the copayment for brand-name drugs. Exceptions to this policy, where a brand-name medication would be acceptable, include prescriptions for the following:

- ✔ Thyroid preparations (Levothroid, Synthroid)
- ✔ Digoxin (Lanoxin)
- ✔ Sustained release theophylline (Theo-Dur, Theolair-SR, others)
- ✔ Anticonvulsants (Tegretol, Dilantin, Mysoline, Depakene)
- ✔ Conjugated estrogens (Premarin, Ogen)

Express Pharmacy Mail Order Plan

You can order up to a **90-day** supply of any prescription drug covered by the Program through Express Pharmacy Services, a Mail Order prescription service. Express Pharmacy works just like a regular drugstore, except by mail. The service can be especially valuable to individuals who have a need for maintenance prescription drugs to assist in control of a chronic medical condition (e.g., blood pressure medication).

The service requires a $7 maximum copayment per prescription per person for each **30-day** supply. For example, if you order a **90-day** supply of Valium your copayment would total $21.

Prescription drug copayments do not apply toward the annual Plan 1 copayment maximum or to the annual Plan 2 Out-of-Pocket Maximum.

Medical

Prescription Drug Plan

How To Use The Mail Order Service

To place your initial order, follow these five steps.

1. For a **12-month** supply, have the physician write an initial prescription for a **90-day** supply, plus three **90-day** refills. Be sure the physician signs the prescription and indicates his/her name, address, and phone number.
2. Complete the **front** of the initial order form shown on the following page.
   - **A.** In the top section, indicate the name, address, and Social Security Number of the retiree or surviving spouse.
   - **B.** List the name, sex, and date of birth of other covered family members in this area.
   - **C.** Indicate the number of prescriptions enclosed, the total copayment amount, and the type of payment enclosed. **Do not send cash!**

Medical

Prescription Drug Plan

DETACH HERE

ENROLLMENT/ORDER FORM FOR NEW PARTICIPANTS

DETACH HERE
E-0617 D-1699

Express Pharmacy Services, P.O. Box 270, Pittsburgh, PA 15230-9949
Please complete this form and return it to Express Pharmacy Services in the enclosed pre-addressed, postage-paid envelope. Be sure to sign the form and enclose your original prescription(s) and payment or charge information. Please complete the Patient Profile on the reverse side.

NAVISTAR.

EMPLOYEE/RETIREE/SURVIVING SPOUSE SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐ (A)

Employee/Retiree/
Surviving Spouse Name _____ Date of Birth _____ Sex _____
First MI Last

Address _____
Street City State Zip

Daytime Phone Number ( ) _____

OTHER FAMILY MEMBERS ELIGIBLE FOR PRESCRIPTION DRUG PROGRAM (B)

Spouse _____ Date of Birth _____ Sex _____
First MI Last

Child _____ Date of Birth _____ Sex _____
First MI Last

Child _____ Date of Birth _____ Sex _____
First MI Last

Child _____ Date of Birth _____ Sex _____
First MI Last

Other _____ Date of Birth _____ Sex _____
First MI Last

Prescriptions are for: [ ] Employee/Retiree [ ] Surviving Spouse [ ] Spouse [ ] Son [ ] Daughter [ ] Other _____
Childproof caps are used for safety in shipping. [ ] Check here if you want non-childproof caps with this order.
Please write the social security number of the employee/retiree/surviving spouse on the back of each prescription.
Number of prescriptions enclosed _____ x $7.00/30-day supply copayment = $ _____
Payment is being made by: Check [ ] Money Order [ ] Credit Card [ ] Total Amount Enclosed $ _____
Please make check or money order payable to Express Pharmacy Services. Do not send cash.
If you use a credit card please identify the credit card you wish to use and give the account number and the expiration date. (C)

JCPenney ☐ MasterCard ☐ VISA ☐ American Express ☐

Account Number _____ Expiration Date _____

Prescription Drug Plan

3. Complete the **Confidential Patient Profile** on the back of the order form. This is important information about allergies and other health conditions the pharmacist needs to know to protect you against adverse reactions to certain prescription drugs.
4. Sign and date the form.
5. Send the form, along with your prescriptions and copayment, to Express Pharmacy in the pre-addressed mailing envelope provided.

Allow **14 days** for delivery via First Class Mail or UPS. When you receive your prescription, you will also receive a refill notice and form for ordering additional prescriptions.

If you have any questions, contact Express Pharmacy at:

1-800-222-8938

Or write:

Express Pharmacy Services
P.O. Box 270
Pittsburgh, PA 15230

Medical

Prescription Drug Plan

DETACH HERE

CONFIDENTIAL PATIENT PROFILE 3

DETACH HERE

Have you ever used Express Pharmacy Services' Home Delivery Prescription Program? [ ] Yes [ ] No

Please complete the section below for all eligible family members. This information will be used to check potential drug interactions when you have prescriptions filled through Express Pharmacy Services.

INCLUDE LAST NAMES IF NOT THE SAME AS EMPLOYEE/RETIREE/ SURVIVING SPOUSE	ALLERGIES					HEALTH CONDITIONS					
	None	Penicillin (1)	Chocolate (2)	Sulfa (3)	Aspirin (4)	Thyroid (5)	Diabetes (6)	Glaucoma (7)	Heart Conditions (8)	High Blood Pressure (9)	Other
Employee/Retiree/Surviving Spouse											
Spouse											
Child											
Child											
Child											

If additional space is needed, please list other allergies or health conditions.

_____

_____

_____

PLEASE READ AND SIGN: 4

I certify that the information provided on this form is correct and authorize the release of all information to the plan sponsor, administrator or underwriter; and I AUTHORIZE EXPRESS PHARMACY SERVICES TO SUBSTITUTE GENERIC DRUGS IN ALL CASES WHEN LEGALLY PERMISSIBLE, IN ACCORDANCE WITH APPLICABLE LAW, CONSISTENT WITH MY DOCTOR'S ORDERS.

_____ (Signature)

_____ (Date Signed)

Medical

Prescription Drug Plan

Expenses Not Covered

All of the exclusions shown on pages 83-86 also apply to the Prescription Drug Plan regardless of whether you are covered under Plan 1 or Plan 2. In addition, benefits for prescription drugs are **not** available for the following:

- ✔ Charges for the administration or injection of any drug.
- ✔ Charges for prescription drug refills in excess of the number specified by the physician.
- ✔ Charges for more than a **30-day** supply of medication, except for:
  - **90-day** supplies you purchase through the Mail Order Drug Plan for which you pay a **3-month** copayment ($21)
  - certain drugs purchased in 100- and 200-unit doses, as described on page 131.
- ✔ Charges for services or supplies provided or specifically excluded under any other part of the Retiree Health Benefit Program.
- ✔ Contraceptive medications, even though they require a prescription, unless prescribed for medical purposes other than contraception.
- ✔ Devices of any type, even if they require a prescription (including contraceptive devices, therapeutic devices, artificial appliances, hypo-spray jet injectors, support garments, bandages, and other similar items).
- ✔ Drugs which are entirely consumed at the time and place of prescription.
- ✔ Needles and syringes, except as provided for the administration of insulin.
- ✔ Prescription drug charges covered under another group benefit plan.
- ✔ Prescription drug refills dispensed more than one year from the date of the physician's last prescription. (A new prescription may be required from the physician if the number of refills has not been indicated on the prescription and the actual number of refills appears excessive).

Prescription Drug Plan

Limitations On Mail Order Plan

The Mail Order Drug Plan does **not** cover:

- ✔ medicines that can be purchased over-the-counter
- ✔ oral contraceptives
- ✔ vitamins
- ✔ drugs used for cosmetic purposes
- ✔ any drug that requires constant refrigeration
- ✔ Nicorette Gum and Nicotine Patches purchased through Express Pharmacy Services

Limitations:

- ✔ "Controlled" substances (called Schedule II drugs) are limited to a **30-day** supply with no refills permitted.
- ✔ Nicorette Gum and Nicotine Patches are provided only through the ValueRx Plan.

Note:
A physician's prescription does not guarantee that the drug prescribed will be covered under the Program. For instance, a physician may write a prescription for a drug which can be dispensed under Federal Law without a prescription. In that case, the drug would not be eligible for coverage. Your physician can best tell you which drugs require a physician's prescription under Federal Law.

General Information

General Information

Right of Recovery

Whenever payments have been made by the Insurance Company or the Company with respect to covered services in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, the Insurance Company or the Company shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as it shall determine:

- ✔ any person to, for, or with respect to whom, such payments were made,
- ✔ any insurance companies, and
- ✔ any other organizations.

The retiree, for himself/herself and on behalf of his or her dependents, shall, upon request, execute and deliver such documents and papers as may be required, and do whatever else is necessary to secure such right to the insurance company or the Company.

In the event that a benefit payment is made under Plan 1 or Plan 2 which is in excess of the benefit payment which should have been provided, the retiree shall be obligated to repay, in cash, the amount of such overpayment, upon appropriate notice of the amount to be repaid. If such repayment is not made within **60 days**, Navistar is authorized to deduct the amounts to be repaid from any amounts payable to the retiree by or on behalf of Navistar. The amount deducted from each benefit check shall be limited to $30.00 or the amount permitted by law, whichever is less. In any case where any overpayment cannot be recovered from the retiree, such overpayment may be recovered from the individual to whom or with respect to whom such overpayment was made. However, no repayment will be required unless notice is given to the retiree by Navistar or Aetna within **60 days** from the date Navistar or Aetna had knowledge of the overpayment, except that no such time limitation shall be applicable in cases of fraud or willful misrepresentation.

Medical

General Information

Transition Rules

If a retiree or covered dependent is hospitalized or admitted to another recognized facility prior to the effective date of the new Program and remains hospitalized after the effective date of the new Program, hospital and other facility expenses will be paid under provisions of the old plan until discharge from the hospital. The same provisions apply for substance abuse and psychiatric confinements in any recognized facility. Non-hospital expenses such as physician charges for surgery, anesthesia, and in-hospital visits would be covered under provisions of the plan that was in effect when the service was rendered.

The exception to the above rule regards pregnancy. If conception occurred before the effective date of the new Program, hospital and physician charges related to the delivery will be covered under the provisions of the old plan. Charges related to the newborn would be covered under provisions of the new Program. The newborn will not be considered a "new dependent."

Dental charges for a recognized course of treatment started while you have dental coverage and completed within **60 days** of the termination of your dental plan will be covered. Recognized course of dental treatment means dentures, fixed bridgework, crowns, inlays, onlays, and root canal therapy. It does not include other types of dental treatment, such as orthodontia, fillings, extractions, scaling, etc. There is no extended coverage for these services.

There is extended coverage for vision benefits; lenses and frames ordered while you have vision coverage and delivered within **60 days** of the date your vision plan terminates are covered. The same is true for hearing aids; aids ordered while you have hearing coverage and delivered within **60 days** of the date your hearing plan terminates will be covered.

Because the new Program will be effective in the middle of the calendar year, deductibles and copayments for 1993 will be prorated based on the actual effective date of the Program. This means that if the effective date of the Program is July 1, 1993, covered services incurred on or after July 1, 1993 would be subject to a $100 deductible per covered individual for Plan 1 and Plan 2. Plan 1 participants would also be subject to a copayment maximum of $150 per covered individual for services incurred on or after July 1, 1993.

Medical

General Information

For current plans that have deductibles and copayments, the FULL amount of those deductibles and copayments met by claims incurred prior to the effective date of the new Program will be applied to the prorated amounts required under the new Program.

If calendar year family limit maximums (deductible and copayments) have been met on covered expenses incurred prior to the effective date, those family limit benefits will apply for the remainder of the calendar year.

Paying For Health Care Coverage

The cost of the Navistar Retiree Health Benefit Program is determined by these two factors:

1. your Medicare eligibility, and
2. the number of eligible adults you cover.

The rates you pay for coverage under Medical Plans 1 and 2 contribute toward part of the total costs for the Navistar Retiree Health Benefit Program. Your initial contribution enrolls you in Plan 1 or Plan 2.

Monthly contribution rates for Medical Plans 1 and 2 are available from Aetna. Call: 1-203-636-0220

Once you are enrolled, you will be billed monthly by Aetna. You can expect to receive your statement 2 to 3 weeks before the payment due date. You may elect to pay your premium in advance, for example, quarterly or semi-annually. As soon as practicable, the Company will make available, on a voluntary basis, the opportunity to have health care premiums automatically deducted from pension payments, provided the premium deduction does not exceed the net pension payment. It is your responsibility to keep your payments current. **If your payments lapse, your coverage will terminate but you may re-enroll in the Program subject to a pre-existing condition provision which is explained on page 150. Payments must be received no later than 45 days after the statement due date.**

Medical

General Information

Your monthly bill not only provides information about your account, it lets you communicate any changes in your status to Aetna. Here's an example of how to use the bill.

1, 2, 3, 4, 5
The top part of the bill provides your account number, the statement date, and the payment due date.

6, 7, 8, 9, 10
The center section lists the coverage period, itemizes any balance brought forward, and indicates the amount due for this statement period.

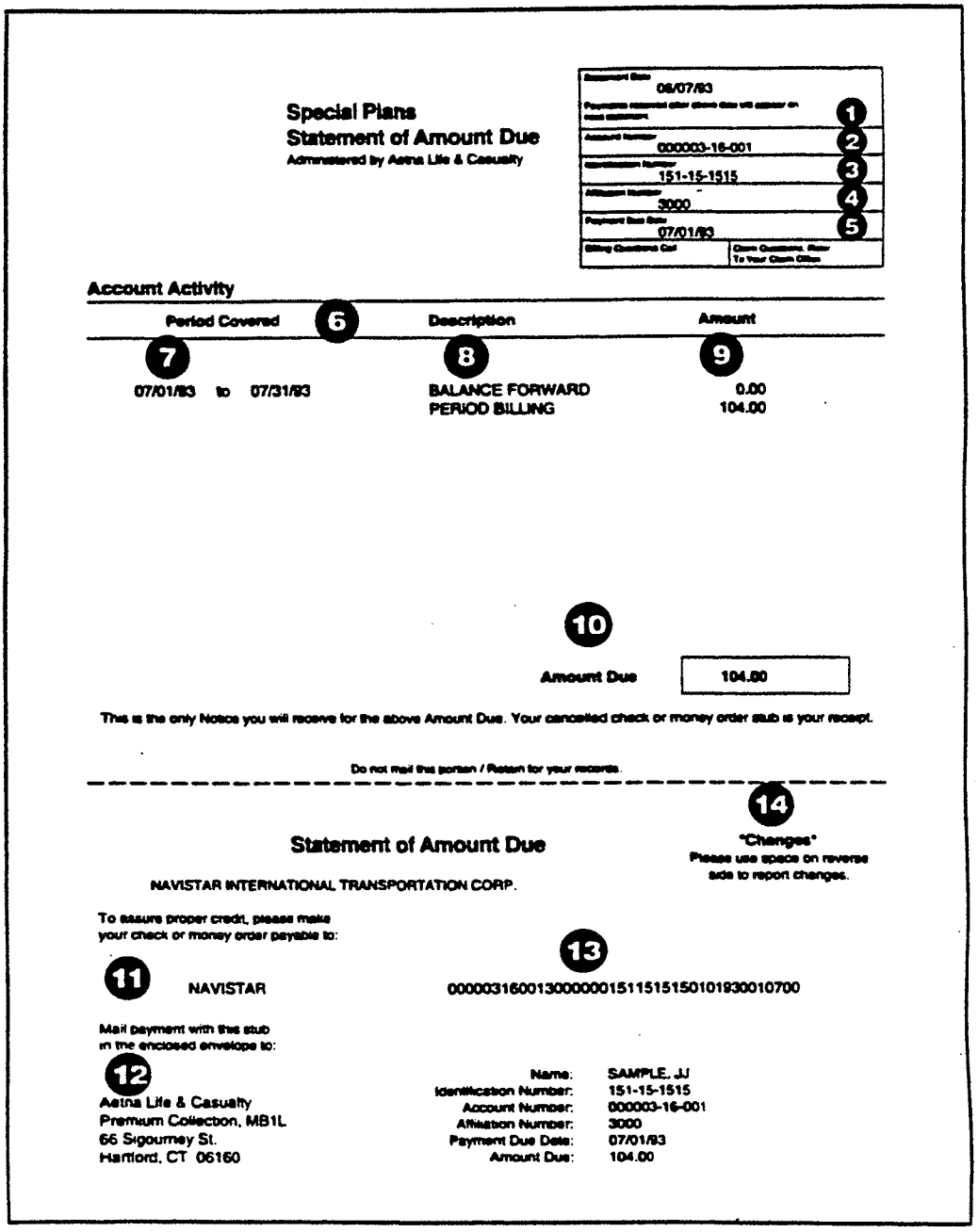
11, 12, 13
Return the bottom portion of the statement to Aetna at the address noted. Enclose a check or money order made payable to Navistar. Indicate if you are paying in advance, and through which dates. As soon as practicable, the Company will make available, on a voluntary basis, the opportunity to have health care premiums automatically deducted from pension payments, provided the premium deduction does not exceed the net pension payment.

14
If you have any "Changes" in status, use the back of the bill to tell us about them.

Medical

General Information

Statement of Amount Due: Front (Sample)



Special Plans
Statement of Amount Due
Administered by Aetna Life & Casualty

Statement Date	06/07/93
Payments received after above date will appear on next statement.	1
Account Number	000003-16-001 2
Identification Number	151-15-1515 3
Affiliation Number	3000 4
Payment Due Date	07/01/93 5
Billing Questions Call	Claim Questions, Refer To Your Claim Office

Account Activity

Period Covered 6	Description	Amount
7	8	9
07/01/93 to 07/31/93	BALANCE FORWARD	0.00
	PERIOD BILLING	104.00

10 **Amount Due** 104.00

This is the only Notice you will receive for the above Amount Due. Your cancelled check or money order stub is your receipt.

Do not mail this portion / Retain for your records.

Statement of Amount Due

14 **"Changes"**
Please use space on reverse side to report changes.

NAVISTAR INTERNATIONAL TRANSPORTATION CORP.

To assure proper credit, please make your check or money order payable to:

11 NAVISTAR

13 00000316001300000015115151501019300107 00

Mail payment with this stub in the enclosed envelope to:

12
Aetna Life & Casualty
Premium Collection, MB1L
66 Sigourney St.
Hartford, CT 06160

Name:	SAMPLE, JJ
Identification Number:	151-15-1515
Account Number:	000003-16-001
Affiliation Number:	3000
Payment Due Date:	07/01/93
Amount Due:	104.00

Medical

General Information

15
The top portion provides information about making payments, getting new ID cards, or getting an additional supply of claim forms.

16
This section lets you tell us about any changes to your address, to dependent status, or to your eligibility for Medicare. You can also check a block to cancel coverage for you and your dependents.

Remember to send the bottom portion of your statement, along with your payment, directly to Aetna at the address indicated. Payment must be received no later than **45 days** after the statement due date.

Medical

General Information

Statement of Amount Due: Back (Sample)

Information That Will Help Us Help You ... (15)

- You can expect to receive your Statement Of Amount Due 2 to 3 weeks prior to each Payment Due Date.
- Report Address Changes promptly in the space provided below or call our Customer Service Telephone Number located on the front of this Statement.
- To assure your payment is applied promptly to your account:
  - Mail payment in the form of a check or money order. Also include your payment stub (bottom portion of this Statement) using the enclosed pre-addressed return envelope.
  - Indicate your Affiliation Number and Identification Number on your check or money order.
  - Mail your payment and stub at least 5 business days prior to the Payment Due Date.
  - Questions regarding your Statement may be brought to our attention by calling our Customer Service telephone number located on the front of this statement or write to us at the following address:

    Aetna Life Insurance Company
    Aetna Health Plans
    Special Plans Unit, MB1K
    151 Farmington Avenue
    Hartford, CT 06156

    (Please include your Address, Telephone Number, Affiliation Number and Identification Number)
- If your Navistar Medical Plan identification card is lost or damaged, a replacement card can be obtained by calling or writing the above Aetna office. Please allow at least 3 weeks for delivery of replacement card.
- Contact the Rockford Claim Office regarding questions about claims or when seeking additional claim forms. The Claim Office telephone number appears on your insurance identification card.
- Questions regarding your Medical Plan may be answered by referencing your Benefit Booklet or contacting the Rockford Claim Office.
- You will have 45 days from payment DUE DATE to pay the amount due or coverage will terminate as of the date through which you are paid.

Use this space to report Changes or Cancel Coverage

Complete Only The Sections You Wish To Change (Signature is Required) (16)

Name (First, Last)
Street Address
City / State / Zip Code
Birthdate

Cancel My Dependents Listed Below		
Name	Relationship	Birthdate

Have you recently become eligible for Medicare because of Disability? _____

If yes, Date Eligible _____

(A copy of your Medicare card must be submitted to the office).

Reminder: If your dependent children, covered by your Policy, are no longer eligible for this coverage, please cancel their coverage by completing the Change Section of this form.

__ I decline coverage for me and all of my covered dependents. (Check box to cancel coverage)

I certify that the above information is accurate and complete. Signature _____ Date _____

Medical

General Information

When Coverage Begins

Retirees and Surviving Spouses

Coverage under your Navistar Retiree Health Benefit Program is effective upon the effective date of this Program and the receipt of payment of your first month's premium. You will receive a premium notice **2 to 3 weeks** before the premium due date. If payment has not been received **within 14 days** after the due date, you will be sent a reminder notice. Then, if we still do not receive your payment **within 31 days** after the premium due date, you will be sent a termination notice, which means you have **14 additional days** to make your premium payment. If we do not receive payment during the **45-day grace period**, you will be terminated from the Program. If you pay during this time period, you will be re-enrolled automatically in the Program.

If you are covered under Plan 1, your coverage and premium amount will automatically change when you become eligible for Medicare at age 65. If you become eligible for Medicare at an earlier age, you must notify Aetna so you can be changed to coverage under Plan 2.

Dependents

Coverage for your dependents will begin on the same date as your coverage.

> Note:
> If you are over age 65, and your spouse is under age 65, you will receive coverage from the same Retiree Health Benefit Program. However, you will participate in Plan 2 and your spouse will participate in Plan 1. If you have a covered dependent who is under age 65, that dependent would also be covered under Plan 1.

Medical

General Information

Making Changes To Your Coverage

The following information describes your enrollment options if you decline Navistar coverage when it is first offered:

- ✔ If you or your spouse has other employment-based coverage which terminates for any reason, you can enroll in Plan 1 or Plan 2 **within 60 days** of your loss of coverage without penalty. You must submit documentation concerning the loss of coverage.
- ✔ If you have elected COBRA coverage and your COBRA rights expire, or if you elect not to continue your COBRA coverage, you may re-enroll in the Plan **within 60 days** of the termination of your COBRA coverage, without penalty.
- ✔ If you choose to enroll in Plan 1 or Plan 2 **after 60 days** of the loss of your employment-based or COBRA coverage, you can do so, but you will be subject to a **12-month** pre-existing condition provision. See description of the pre-existing condition provision on the next page.
- ✔ If your coverage under Plan 1 or Plan 2 lapses because you have not paid the premium within the **45-day grace period**, you can re-enroll in either Plan 1 or Plan 2, but a **12-month** pre-existing condition provision applies. See description of the pre-existing condition provision on the next page.
- ✔ If you have other individual or group coverage and it terminates for any reason, you can enroll in Plan 1 or Plan 2 **within 60 days** of your loss of coverage, without penalty, as long as the premium paid for the previous coverage is equal to or greater than the applicable 1993 Plan 1 or Plan 2 retiree-paid premium or the future applicable Plan 1 or Plan 2 retiree-paid premium, whichever is more. You must submit documentation concerning the loss of coverage and the amount of premium.
- ✔ If you do not enroll in Plan 1 initially, or in Plan 2 at age 65, and have no other coverage, you may enroll at any time, but you will be subject to a **12-month** pre-existing condition provision. See description of the pre-existing condition provision on the next page.
- ✔ If you receive health care coverage from a public plan (such as Medicaid, State Workers' Compensation or Veterans' programs) and lose eligibility for this coverage for any reason, you may enroll in Plan 1 or Plan 2 at any time without penalty.

If you choose not to enroll in Plan 1, you may still enroll in Plan 2 when you reach age 65 or become eligible for Medicare, without penalty.

Medical

General Information

If you die, and your surviving spouse wants coverage under the Navistar Retiree Health Benefit Program, your spouse must furnish documentation to Aetna **within 60 days** of the date of death. Your spouse's coverage will be effective the first of the month following Aetna's receipt of the required documentation and premium.

Pre-Existing Condition

Plan 1 and Plan 2 do not cover expenses for the treatment of pre-existing conditions during the **first 12 months** following the specific enrollment or re-enrollment situations described on pages 13-14 and 149. **A pre-existing condition is an injury or disease for which treatment was received or for which drugs were prescribed during the 12-month period preceding the date of enrollment or re-enrollment.** The pre-existing condition provision does not apply to newborns.

When Coverage Ends

Retirees and Surviving Spouses

Your Navistar Retiree Health Benefit Program coverage will end on the earlier of these two occasions:

1. The date you are no longer eligible for coverage; or
2. The last day of the period for which you have made the required contributions for coverage. The Program allows a **grace period of 45 days** after the statement due date.

Dependents

Your dependent's coverage will terminate on the earlier of these two occasions:

1. A dependent becomes covered as a retired employee; or
2. A dependent is no longer an eligible dependent as defined.

Medical

General Information

Filing A Claim: Steps To Follow

Navistar has contracted with Aetna to process claims. Claims must be submitted to the Navistar/Aetna Benefits Payment Office no later than one year following the date of service. Failure to file the claim within the one-year timeframe will not invalidate claims where it is shown that it was not reasonably possible or not practicable to file within such time.

To receive reimbursement for covered services and supplies, follow these steps.

1. **If you are covered under Plan 1,** submit a completed claim form for a new illness to the Navistar/Aetna Benefits Payment Office. **In most cases, you need to complete only one claim form each calendar year for each covered individual.** Then, simply forward any additional bills to the Navistar/Aetna Benefits Payment Office. For some claims, such as convalescent care facility benefits, your physician may need to send Aetna periodic reports to verify the need for continued service.
2. **If you are covered under Plan 2,** Medicare will pay benefits first. Your Medicare Part A providers will submit your Part A expenses directly to Medicare; your Medicare Part B providers MAY submit your Part B expenses directly to Medicare. Ask your physician if he/she will submit claims to Medicare for you. When you receive your Explanation of Medicare Benefits form, forward it with a completed claim form to the Navistar/Aetna Benefits Payment Office. **You need only submit one completed claim form each year for each covered family member.**
3. **If you are covered under Plan 2 and enrolled in Medicare Direct,** your Medicare Part A providers will submit your Part A expenses directly to Medicare; your Medicare Part B providers MAY submit your Part B expenses directly to Medicare. Ask your physician if he/she will submit claims to Medicare for you. If not, you will have to submit them yourself. Medicare will automatically submit Part B claims to the Navistar/Aetna Benefits Payment Office for you. (See pages 159-160 for more information on Medicare Direct.)

Medical

General Information

Medical Benefits Request Form

A sample Medical Benefits Request Form is shown here. To speed your payment, be sure to complete all of the information that is requested. Pay careful attention to the following information.

1. **Section 1, Cardholder Information.**
   This is information about you, the Retiree or Surviving Spous
   - ✔ Fill in your Social Security Number. Your claim can't be processed without it.
   - ✔ If you are employed somewhere other than Navistar, tell u the name of your employer.
   - ✔ Check a box if you have other health care coverage.
   - ✔ Write in the Spouse's name and Social Security Number, t This is important if there is more than one health care plar
2. **Section 2, Patient Information.** This is the information we ne about the person who actually received medical care.
   - ✔ Check a box to tell us whether the patient is you, a spouse another covered dependent.
   - ✔ Also, if the patient is a dependent and has a Social Securit Number, be sure to fill it in.
   - ✔ If medical care was provided because of an accident, tell us what happened, when, where, and how the accident occurred.
   - ✔ If the patient is a dependent child, we need to know if the dependent is employed or has health care coverage other than through the Navistar Retiree Health Benefit Program
3. **Sign and date the form.**
   Your signature authorizes Aetna to get the information it needs to process your claim for benefits. The date lets us kno when your claim was submitted and when it was processed for payment.

Medical

General Information

Medical Benefits Request Form: Front (Sample)

NAVISTAR.

RETURN FOR PROCESSING TO:
Navistar/Ætna Benefits Payment Office
P.O. Box 5367
Rockford, IL 61125

MEDICAL BENEFITS REQUEST FORM

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY

A COMPLETED SIGNED BENEFITS REQUEST FORM must be submitted once for yourself and once for your spouse each calendar year. SECTION I (EMPLOYEE/PATIENT INFORMATION) is to be completed by the employee. SECTION II (PHYSICIAN or PROVIDER INFORMATION) on the reverse side, must be completed by the provider of services. A completely itemized bill may be submitted in place of Section II. An itemized bill is one that shows the patient's name, relationship, date(s) of service, diagnosis and signature of physician or supplier. (Please Use Black Ink)

SECTION I: TO BE COMPLETED BY EMPLOYEE/RETIREE OR SURVIVING SPOUSE — TYPE OR PRINT ALL INFORMATION

1 CARDHOLDER INFORMATION

Name _____ Soc Sec No | | | | | | | | | |

Address _____ City _____ State _____ Zip _____

Check if New Address ☐ Telephone No ( ) _____ Work Location _____

Have You Terminated Employment with Navistar? Yes ☐ No ☐ If Yes, Date _____

Are You Employed Elsewhere? Yes ☐ No ☐ If Yes, Name and Address of Other Employer _____

Do You Have Other Group, HMO or Medicare Coverage? Yes ☐ No ☐ If Yes, Medical ☐ Dental ☐ Vision ☐ Hearing ☐ HMO ☐ Medicare ☐ Name of Other Insurer, Address and Policy No (if known) _____

If Married, Spouse's Name _____ Birthdate ___ ___ ___ (Mo Da Yr) Is Your Spouse Employed? Yes ☐ No ☐

If Yes, Spouse's Soc Sec No | | | | | | | | | | Name and Address of Spouse's Employer _____

Does Your Spouse Have Other Group, HMO or Medicare Coverage? Yes ☐ No ☐ If Yes, Medical ☐ Dental ☐ Vision ☐ Hearing ☐ HMO ☐ Medicare ☐
Name of Other Insurer, Address and Policy No (if known) _____

2 PATIENT INFORMATION

Sex Male ☐ Female ☐

Name _____ Soc Sec No | | | | | | | | | | Birthdate ___ ___ ___ (Mo Da Yr)

Address Same as Employee ☐ Other _____

Relationship to Insured Self ☐ Spouse ☐ Child ☐ Other _____ Was Condition Related to Patient's Employment? Yes ☐ No ☐

Was Condition Related to an Accident? Yes ☐ No ☐ If Yes, Date ___ ___ ___ (Mo Da Yr) Time _____ AM ☐ PM ☐ Description _____

If Patient is a Dependent Child
Full Time Student (if over age 19)? Yes ☐ No ☐ If Yes Where _____
Is Dependent Child Shown as Exemption on Your Federal Income Tax Return? Yes ☐ No ☐
Is Dependent Child Employed? Yes ☐ No ☐ If Yes Name and Address of Employer _____

Does Dependent Child Have Other Group HMO or Medicare Coverage? Yes ☐ No ☐ If Yes, Medical ☐ Dental ☐ Vision ☐ Hearing ☐ HMO ☐ Medicare ☐
Name of Other Insurer Address and Policy No (if known) _____

3

To all physicians and other health professionals, and hospitals and other health care institutions
You are authorized to provide Ætna Life Insurance Company, Ætna Life Insurance Company of Illinois and any independent claim administrators and consulting health professionals and utilization review organizations with whom Ætna has contracted, information concerning health care, advice, treatment or supplies provided the Patient (including that relating to mental illness). This information will be used for the purpose of evaluating and administering claims for benefits.
Ætna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract.
This authorization is valid for the term of coverage of the policy or contract under which a claim has been submitted.
I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Date _____ Patient or Parent/Guardian Signature _____

NOTE TO EMPLOYEES Claim forms and envelopes may be obtained from your work location. Retirees and surviving spouses will be sent forms with each claim payment.

PRINTED IN USA REV 10/90

Medical

General Information

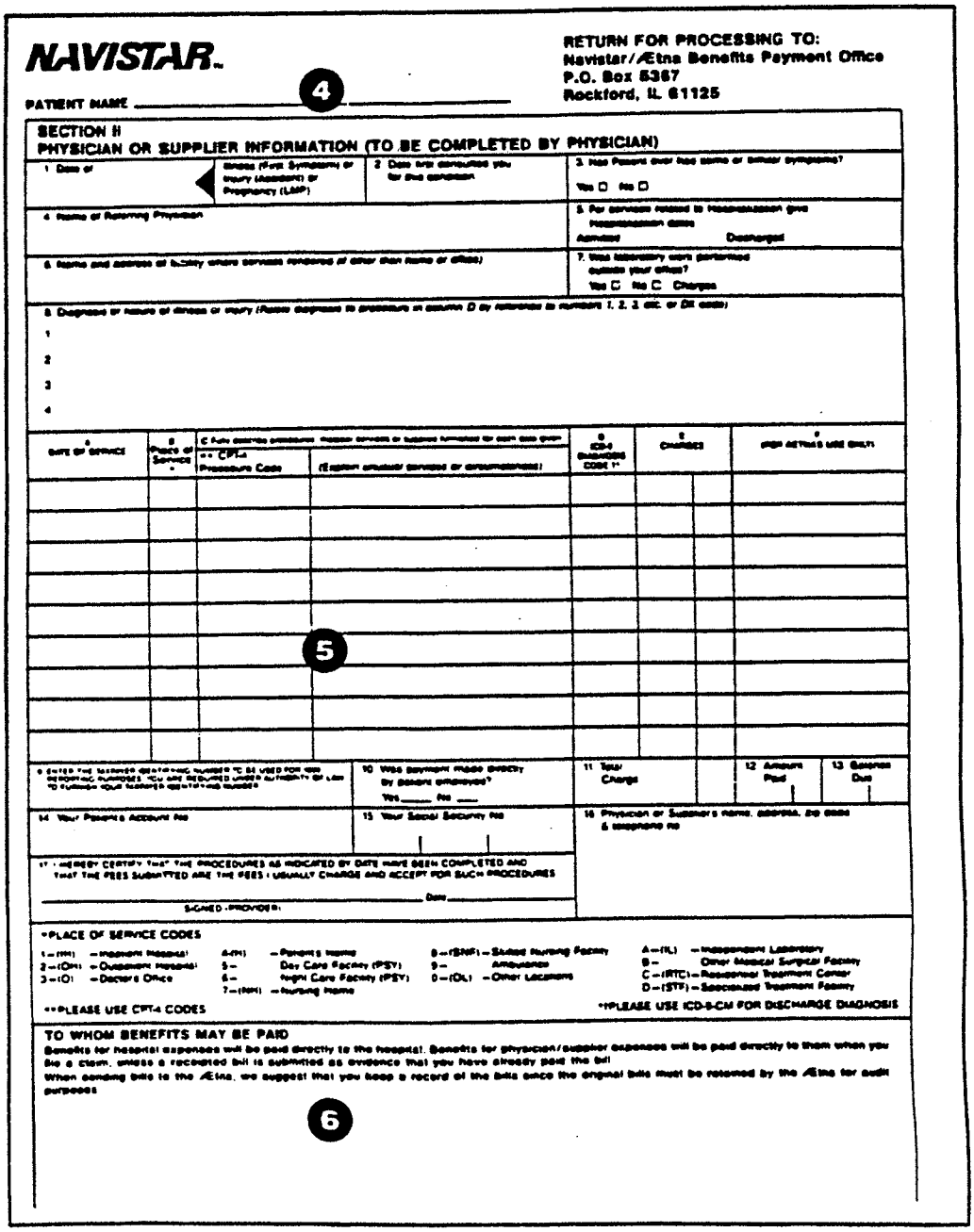
The physician must complete the back of the form.

4. First, he or she must indicate the name of the patient.
5. In this section, the physician provides a complete description of the dates of service, types of service, diagnosis, and charges. He or she must date and sign the form, and indicate if payment was made by you toward services.
6. This section explains how benefits will be paid: directly to a hospital, and/or directly to a physician UNLESS you include a receipt or the claim is clearly marked "Paid." Please keep a copy of any receipts submitted for your records.

   The Company, upon receipt of a notice of claim, will furnish to the claimant forms for filing proofs of claim. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements as to proof of his claim upon submitting written proof covering the occurrence, character, and extent of the occurrence for which claim is made.

General Information

Medical Benefits Request Form: Back (Sample)



NAVISTAR.

RETURN FOR PROCESSING TO:
Navistar/Ætna Benefits Payment Office
P.O. Box 5367
Rockford, IL 61125

PATIENT NAME _____ 4 _____

SECTION II
PHYSICIAN OR SUPPLIER INFORMATION (TO BE COMPLETED BY PHYSICIAN)

1. Date of | Illness (First Symptom) or Injury (Accident) or Pregnancy (LMP)
2. Date first consulted you for this condition
3. Has Patient ever had same or similar symptoms? Yes ☐ No ☐
4. Name of Referring Physician
5. For services related to hospitalization give Admitted / Discharged
6. Name and address of facility where services rendered (if other than home or office)
7. Was laboratory work performed outside your office? Yes ☐ No ☐ Charges

8. Diagnosis or nature of illness or injury (Relate diagnoses to procedures in column D by reference to numbers 1, 2, 3, etc. or DX code)
1
2
3
4

A DATE OF SERVICE	B Place of Service *	C Fully describe procedures, medical services or supplies furnished for each date given: ** CPT-4 Procedure Code / (Explain unusual services or circumstances)	D ICD-9 DIAGNOSIS CODE †*	E CHARGES	FOR AETNA USE ONLY
		5			

G Enter the taxpayer identifying number to be used for this transaction. You are required under authority of law to furnish your taxpayer identifying number.

10. Was payment made directly by patient employee? Yes ____ No ____
11. Total Charge
12. Amount Paid
13. Balance Due
14. Your Patient's Account No
15. Your Social Security No
16. Physician or Supplier's name, address, zip code & telephone no

17. I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE FEES I USUALLY CHARGE AND ACCEPT FOR SUCH PROCEDURES
SIGNED - PROVIDER Date

*PLACE OF SERVICE CODES
1 – (IH) – Inpatient Hospital
2 – (OH) – Outpatient Hospital
3 – (O) – Doctor's Office
4 – (H) – Patient's Home
5 – Day Care Facility (PSY)
6 – Night Care Facility (PSY)
7 – (NH) – Nursing Home
8 – (SNF) – Skilled Nursing Facility
9 – Ambulance
0 – (OL) – Other Locations
A – (IL) – Independent Laboratory
B – Other Medical Surgical Facility
C – (RTC) – Residential Treatment Center
D – (STF) – Specialized Treatment Facility

**PLEASE USE CPT-4 CODES
†PLEASE USE ICD-9-CM FOR DISCHARGE DIAGNOSIS

TO WHOM BENEFITS MAY BE PAID
Benefits for hospital expenses will be paid directly to the hospital. Benefits for physician/supplier expenses will be paid directly to them when you file a claim, unless a receipted bill is submitted as evidence that you have already paid the bill.
When sending bills to the Ætna, we suggest that you keep a record of the bills since the original bills must be retained by the Ætna for audit purposes.

6

Medical

General Information

Explanation of Benefits (Plan 1)

When your claim is processed by Aetna, you will receive an Explanation of Benefits (EOB) detailing submitted and covered expenses. Be sure to keep your EOB for your information and records. **The claims office will not issue a duplicate.**

Explanation of Medicare Benefits (Plan 2)

If you are participating in Plan 2, you will receive an Explanation of Medicare Benefits (EOMB) since Medicare pays your benefits first. Unless you are enrolled in the Medicare Direct Program, you must submit this EOMB to Aetna to receive benefits payable under Plan 2.

Here is a sample of the information you will receive for Medicare Part A claims.

Nos. 1-2:
The top section shows your name, address and Medicare number.

Nos. 3-5:
This section shows the provider from whom you received services for the dates of the first and last service, and type of service provided.

No. 6:
This is the amount Medicare paid for covered services.

No. 7:
This is your Medicare carrier's address and telephone number.

General Information

Explanation of Medicare Benefits: Part A (Sample)

SST930128

U.S DEPARTMENT OF HEALTH AND HUMAN SERVICES/HEALTH CARE FINANCING ADMINISTRATION

MEDICARE BENEFIT NOTICE

DATE 02/11/93

1 John Doe
123 Main Street
Anytown, USA 12345

HEALTH INSURANCE CLAIM NUMBER

2 999-99-9999A

Always use this number when writing about your claim

This notice shows what benefits were used by you and the covered services not paid by Medicare for the period shown in Item 1. See other side of this form for additional information which may apply to your claim.

1 SERVICES FURNISHED BY	DATE(S)	BENEFITS USED
3 SWEDISH COVENANT 5145 N CALIFORNIA AV CHICAGO IL 60625	01/14/93 THRU 01/21/93 4	7 INPATIENT HOSPITAL DAYS 5

2 PAYMENT STATUS 6

MEDICARE PAID ALL COVERED SERVICES EXCEPT:
$676.00 FOR THE INPATIENT DEDUCTIBLE.

IF NO-FAULT INSURANCE, LIABILITY INSURANCE, WORKERS' COMPENSATION, DEPARTMENT OF VETERANS AFFAIRS, OR, IN SOME CASES, A GROUP HEALTH PLAN FOR EMPLOYEES ALSO COVERS THESE SERVICES, A REFUND MAY BE DUE THE MEDICARE PROGRAM. PLEASE CONTACT US IF YOU ARE COVERED BY ANY OF THESE SOURCES. YOU DO NOT HAVE TO CONTACT US TO REPORT A MEDICARE SUPPLEMENTAL (MEDIGAP) POLICY.

7 Your Medicare Carrier
Address
Telephone Number

If you have any questions about this notice, call or write

TELEPHONE NUMBER

FORM HCFA-1533 (3-87)

Medical

General Information

Explanation of Medicare Benefits: Part B (Sample)

This is not a bill.

Explanation of Your Medicare Part B Benefits

JOHN DOE
500 WALL ST #622
SEATTLE, WA 98121-1509

Your Medicare number is: 533-01-0692D

1

Summary of this notice dated March 24, 1993

Total charges:	$ 56.53
Total Medicare approved:	$ 47.57
We are paying you:	$ 38.05

Details about this notice (See the back for more information.)

Control number 0121-6233-60000

2

You received these services from your provider: SEATTLE RADIOLOGISTS. Mailing address: 1229 MADISON 9TH FL, SEATTLE, WA 98104-1357

Services and Service Codes	Dates	Charges	Medicare Approved	Notes
DR T LARSON				
1 x-ray exam series, abdomen [74022-26] professional charge	February 16, 1993	$ 18.40	$ 15.49	a
1 chest x-ray [71020-26] professional charge	February 18, 1993	12.94	10.88	a
1 x-ray exam of sinuses [70220-26] professional charge	February 18, 1993	14.59	12.27	a
1 chest x-ray [71010-26] professional charge	February 18, 1993	10.60	8.93	a
	Total	$ 56.53	$ 47.57	

Your provider did not accept assignment. We are paying you the amount that we owe you. See #4 on the back of this notice.

Notes:

a The approved amount for this service is based on the Medicare fee schedule in this locality.

3

Here's an explanation of this notice:

Of the total charges, Medicare approved	$ 47.57	See #4 on the back.
Less Medicare copayment amount	- 9.52	We pay 80% of the approved amount; you pay 20%.
Approved amount less copay	$ 38.05	You have met the deductible for this year.
Medicare owes	$ 38.05	
We are paying you	$ 38.05	Please cash the enclosed check as soon as possible.

IMPORTANT: If you have questions about this notice, call KING COUNTY MED BLUE SHIELD at (206) 464-3711 or see us at 1800 9TH AVENUE, SEATTLE, WASHINGTON. You will need this notice if you contact us.
To appeal our decision, you must WRITE to us before December 24, 1993 at P.O. BOX 21248, SEATTLE, WA 98111-3248.
See #2 on the back.

4

General Information

The form on the preceding page is a sample of the information you will receive for Medicare Part B claims.

No. 1:
The top of the statement indicates your name, address, Medicare number, and a summary of the charges submitted and the amount Medicare paid.

No. 2:
The middle of the statement provides more detail about the charges. It includes the name of the physician, services provided, total amount of the charge, and the Medicare approved amount for each covered service.

No. 3:
The next section explains how your payment was determined. It calculates the total of Medicare approved charges, copayment amount, and amount being paid.

No. 4:
At the bottom of the statement, please note the name and telephone number of your Medicare carrier, and how to appeal the claim if you have information that would influence the payment decision.

The Medicare Direct Program

Medicare Direct is a computer system that forwards information about claims paid under Medicare Part B directly to Aetna. The program means less paperwork and faster claim payments for you. It is available in most states.

Who Is Eligible?

You are eligible to participate in the program if you are a:

- ✔ retiree age 65 or over who is enrolled in Medicare Part B,
- ✔ spouse age 65 or over who is enrolled in Medicare Part B, **and**
- ✔ the Navistar Retiree Health Benefit Program and Medicare are the only health care coverages you have.

The Medicare Direct program will process claims for just about every service that is covered under Medicare Part B. It will not process claims for Medicare Part A services or for Prescription Drugs.

Medical

General Information

How Do I Enroll?

If you are eligible for Medicare and not already participating in the Medicare Direct program, call Navistar at **1-312-836-3187** and request an enrollment form and brochure. Complete the form and return it to Navistar. It's a convenient way to save time, money, and paperwork!

If you have not yet reached age 65, Navistar will automatically send you an enrollment form two months before your 65th birthday. Complete the form and return it to Navistar so you'll be enrolled in the Program when you are Medicare-eligible.

Aetna Customer Relations

If you have any questions about claims or benefits, contact the Aetna/Rockford Benefits Payment office. It is staffed with experienced customer relations specialists to help you with questions about:

- ✔ Dependent eligibility;
- ✔ Filing claims;
- ✔ How benefits are coordinated between plans;
- ✔ How to get additional claim forms; and
- ✔ Other types of benefit information.

Aetna/Rockford Benefits Payment Office
Hours are 8:00 a.m. to 5:00 p.m.,
(Central Standard Time)
Call **1-800-435-2969**

Be sure to have the following information ready when you call:

- ✔ Your Social Security Number;
- ✔ Your address and telephone number;
- ✔ Patient's name;
- ✔ Physician's diagnosis;
- ✔ The physician's name, specialty, address and telephone number.

Medical

General Information

Q: How long will it take to process my claim?

A: You should expect to receive payment within **10 working days** after the date your claim is received at the Aetna/Rockford Benefits Payment office.

Q: What can I do to speed up the processing of my claim.

A: The most important thing in processing a claim is to have complete information provided on the claim form and any supporting documentation. Otherwise, the claim may have to be pended, or held up while we wait for more information. This costs you time, and Navistar money. **Some important don'ts:**

- ✔ **Don't** submit a list of expenses you've prepared yourself. Send the actual bill(s) showing the name of the provider, the name of the patient, date and type of service, and the fee charged.
- ✔ **Don't** send canceled checks, cash register receipts, or bills with a "previous balance" or "balance forward" column. These can't be processed.
- ✔ **Don't** request copies of the bills you've submitted. Aetna must keep those with your file for audit purposes. Make copies of your claim and bills **before** you send them to Aetna.

Q: If I enroll in Medicare Direct, how will I know that Medicare sent my Part B claims on to Aetna to be processed?

A: When you receive your Explanation of Medicare Benefits statement, look for the following phrase: "Unpaid charges have been submitted for consideration to your complementary Medicare Insurer." This means that your claim was sent to Aetna. If you don't see this phrase, or if you don't receive payment within two weeks, contact your physician to be sure he/she submitted your claim.

Identification Cards

You'll receive an ID card when your coverage under Plan 1 or Plan 2 is effective. The ID card includes your name and Social Security number. **Keep it in a safe place. You'll need to show the card when you need health care services.** If your ID card is lost, misplaced, or stolen, contact Aetna at **1-203-636-0220.**

Medical

General Information

If Your Claim Is Denied

If a claim is wholly or partially denied under the Navistar Retiree Health Benefit Program, you will receive notice of the decision within **90 days** of receipt of the claim. The notice will be in writing, and will provide:

- ✔ The specific reason or reasons for the denial.
- ✔ Specific reference to pertinent provisions of the Program on which the denial is based.
- ✔ A description of any additional material or information necessary for you to resubmit the claim, and an explanation of why such material or information is necessary.
- ✔ An explanation of the claim review procedure.

You will have the opportunity to appeal a denial of a claim. For a full and fair review, send a written application to:

Manager, Employee Insurance
Navistar International Transportation Corp.
455 North Cityfront Plaza Drive
Chicago, IL 60611

You must make your appeal within one year of the date you receive the notice of denial of benefits. If you decide to appeal, you or your authorized representative:

- ✔ May review pertinent documents relating to the denial.
- ✔ May submit issues and comments in writing.

A decision will be made promptly, but not later than **60 days** after receiving your request for review. If special circumstances require an extension of time for processing, you will be notified in writing. In that case, a decision will be made as soon as possible, but not later than **120 days** after receiving your request for review.

The decision on the review of your appeal will be provided in writing. It will include specific reasons for the decision, and specific references to pertinent provisions of the Program on which the decision was based.

If a claim is denied under Plan 2 because Medicare did not cover the expense, you cannot appeal the denial unless Medicare reverses their initial denial of payment. You must then furnish Aetna with written documentation from Medicare showing their payment.

Health Benefit Plan Committee

A seven (7) member joint Health Benefit Plan Committee has been established to resolve disputes following the regular claims procedure. Two members of the committee have been selected by the UAW; three by Navistar; one non-UAW retiree shall be appointed as described in the **Shy Settlement Agreement**; and one neutral member shall be elected by the other six. The Health Benefit Plan Committee may review and resolve benefit and eligibility disputes after the claim review procedure and will act in its sole discretion in resolving such disputes. The decision of the Health Benefit Plan Committee shall be final and binding on all parties.

In order to appeal a benefit denial or eligibility dispute to the Health Benefit Plan Committee, write to:

Health Benefit Plan Committee
c/o Navistar International Transportation Corp.
455 North Cityfront Plaza Drive
Chicago, IL 60611

Be sure to include all relevant documentation along with the reason for your request for review. In this appeal process, you are free to obtain assistance from your union representative, if applicable.

The Health Benefit Plan Committee may not approve payment for any benefit that is not covered under the Program. Any determination made by the Committee will be consistent with the Plan Document, but the Committee may consider relevant past practices, prior letters of agreement, or similar information in interpreting the Program.

Medical

General Information

About Medicare

Medicare is a medical benefits plan provided by the United States government. It helps people age 65 and over, and some disabled people under age 65, to pay for the high cost of health care. Medicare has two parts:

- ✔ Part A (Hospital insurance). It helps pay for inpatient care and for certain follow-up care after you leave the hospital.
- ✔ Part B (Medical insurance). It helps pay for physicians' fees, outpatient services and many other medical items and services not covered under Hospital insurance.

Who Is Eligible

Most people age 65 and over are eligible for Medicare Part A benefits at no charge if they are eligible for Social Security or Railroad Retirement benefits.

People eligible for Medicare Part A may also enroll for Medicare Part B. **There is a monthly premium for Part B coverage.**

When to Enroll

When you reach age 65, you must enroll in Medicare Parts A and B for primary coverage, and you may participate in Navistar Medical Plan 2 for supplemental coverage.

If you are under age 65 when you retire, you must enroll in Medicare Parts A and B within the three months before your 65th birthday. Failure to do so may result in a delay in coverage, and the payment of fees for late enrollment.

If you are age 65 or over when you retire, you must immediately enroll in Medicare Parts A and B, if you have not done so already. The coverage provided by Medical Plan 2 assumes that you have enrolled in Medicare and that Medicare is your primary coverage.

> If you are eligible for Medicare Part B and do not enroll, you will have to pay whatever Medicare would have paid toward Part B covered expenses.

Medical

General Information

About Medicare Part A

Medicare Part A is funded by Social Security taxes paid by you and your employer throughout your working years. It is available at no charge beginning at age 65.

Some people age 65 or older do not meet the requirements for Medicare Part A at no charge. If you are in that category, you can get Part A by paying a monthly premium to Medicare. Plan 2 will only pay if you participate in Part A.

Medicare Part A provides coverage for these types of expenses:

- ✔ Inpatient hospital care,
- ✔ Skilled nursing facility care,
- ✔ Home Health Care, and
- ✔ Hospice care.

About Medicare Part B

Medicare Part B is called Supplementary Medical Insurance or SMI. You must enroll for Medicare Part B and pay a monthly premium for it. The premium for SMI is generally deducted from your monthly Social Security check.

Services covered under Medicare Part B include:

- ✔ Physicians' services,
- ✔ Diagnostic X-ray and laboratory tests,
- ✔ Emergency room care,
- ✔ Radiation treatments.

Contact Social Security to find out exactly whether a certain procedure is covered under Medicare Part B. Social Security can also provide information about coverage that is supplemental to Medicare for these services.

Medicare Assignment and Allowable Amounts

Benefits are paid based on what Medicare determines is an allowable amount for covered medical services. The Medicare-approved allowable amount for any procedure is the most Medicare will consider for payment. Once you meet an annual deductible, Medicare Part B will pay 80% of the allowable amount for a service.

Medical

General Information

A physician who accepts Medicare assignment is one who will bill Medicare directly and accept payment from Medicare. The physician will also accept the Medicare-approved allowable amount as the full fee. These health care providers are known as "Medicare participating." While a doctor may choose not to accept assignment, there are limits on the amount that may actually be charged to a patient. For 1993, the limit is 115% of the Medicare-approved charges.

The rules on Medicare-approved amounts are set by the Federal government and are binding in each state.

Appealing a Benefit Denial

As with your Navistar benefits, you can ask the agency that processes Medicare claims for a review of any claim that is denied. Keep copies of all bills and receipts. Also, keep records of all telephone conversations regarding your medical bills, noting the date, the person to whom you spoke and the content of the conversation. **Remember, to appeal a denial under Plan 2, you must first appeal to Medicare and they must cover the service.**

Q: How much is the monthly premium for Medicare Part B?

A: When you sign up for Medicare Part B, you will receive an information package which will tell you the amount of the premium and how to pay it. The premium is recalculated each year by the government and is designed to cover about 25% of the costs of Medicare Part B. If you don't sign up for Medicare Part B when you are eligible, you may pay more for the coverage when you do enroll.

Q: Where can I get more information about Medicare?

A: "The Medicare Handbook" is the best source of information. Call 1-800-772-1213, or write:

Medicare
US Department of Health-Human Services
Health Care Financing Administration
6325 Security Blvd.
Baltimore, MD 21207

Medical

General Information

COBRA

Under a federal law known as COBRA, an employee, his/her spouse and dependent children have a right to purchase continuation coverage from the Company if coverage under the Program would terminate for them because of any of the following **six (6) events**:

1. The death of a covered employee.
2. The termination (other than by reason of such employee's gross misconduct), or reduction in hours, of the covered employee's employment.
3. The divorce or legal separation of the covered employee from the employee's spouse.
4. With respect to the employee's spouse or dependent children, the covered employee becoming entitled to benefits under Medicare.
5. A dependent child ceasing to be a dependent child under the generally applicable requirements of the Program.
6. A proceeding in a case under Chapter 11, United States Code, with respect to the employer from whose employment the covered employee retired at any time prior to a substantial elimination of coverage.

The continuation of coverage requires the payment of premiums. The premiums will be based on the amount necessary to cover 102% (150% during continuation for disability) of the Company's cost of providing coverage under the Program.

Coverage may be continued for the following periods, unless an event occurs that terminates the right to continuation coverage:

1. If coverage is lost because of termination of employment or reduction in hours, coverage may be continued for **18 months**. The period is **29 months** for a person who was determined under Title II or XVI of the Social Security Act to have been disabled on the date of the employee's termination of employment or reduction in hours, if notice of such determination was given to the Company during the **18-month** period.
2. If coverage is lost because of a Chapter 11 filing, coverage can be extended for the life of the retired employee and for **36 months** after the retired employee's death for the retired employee's surviving spouse and dependent children.

General Information

3. If coverage is lost because of Medicare eligibility of the employee, coverage may continue for **36 months** after the Medicare eligibility of the employee.
4. If coverage is lost for other reasons, coverage may continue for **36 months** after the event that caused the loss of coverage.

Coverage cannot be continued after any of the following events have occurred:

1. The premium was not paid on a timely basis.
2. The employee, spouse or dependent child became covered under any other group health plan that did not contain any exclusion or limitation with respect to any pre-existing conditions.
3. The employee, spouse or dependent child became covered by Medicare, except for continuations under Chapter 11 proceedings.
4. The disability that provided for extended coverage beyond the **18-month** period ceased.
5. The employer ceased to provide any group health plan coverage to any employee.

When an event occurs that entitles an individual to continuation of coverage, the Plan Administrator will notify the person of his/her continuation rights and the **60-day** period during which an election must be made. If the event is divorce, or a child ceasing to be a dependent child, the retired employee, spouse or dependent must notify the Plan Administrator of the event.

If coverage was continued through the end of the applicable monthly period, the covered person will have the option to enroll under a conversion health plan otherwise generally available under the Company Program.

Medical

General Information

Converting to An Individual Policy

When retiree, dependent or surviving spouse coverage under the Navistar Retiree Health Benefit Program ends, a retiree, dependent or surviving spouse may convert, without Evidence of Insurability, to an individual policy of hospital and medical expense benefits. The policy will be issued by the Aetna Life Insurance Company, and the cost must be paid in full by the insured. The individual policy does not, however, provide all the same benefits as your Navistar Retiree Health Benefit Program.

Application must be made and the first premium must be paid to the insurance company **within 31 days** after group coverage terminates. Applications are available from your local Human Resources representative. The conversion privilege through Aetna would not be available if Navistar were to terminate its contract with Aetna. In that case, Navistar would provide conversion through another carrier.

Medical

General Information

Administrative Information About The Retiree Health Benefit Program Under The Navistar International Transportation Corp. Retiree Health Benefit and Life Insurance Plan

Plan Name	Navistar International Transportation Corp. Retiree Health Benefit and Life Insurance Plan
Employer Identification Number	36-1264810
Plan Number	584
Plan Year	November 1 through October 31
Type of Plan	Welfare plan providing health benefits
Type of Administration	The Plan is sponsored by Navistar International Transportation Corp. Aetna Life Insurance Company acts as a contract administrator for processing claims.
Sponsoring Employer	Navistar International Transportation Corp. 455 North Cityfront Plaza Drive Chicago, IL 60611 (312) 836-2000
Plan Administrator	Navistar International Transportation Corp. 455 North Cityfront Plaza Drive Chicago, IL 60611 (312) 836-2000
Agent for Service of Legal Process	Navistar International Transportation Corp. 455 North Cityfront Plaza Drive Chicago, IL 60611 (312) 836-2000
Contributions to the Plan	Retiree contributions are set by the Plan Administrator to cover a portion of total costs. Employer contributions cover all remaining costs of the Plan.

Medical

General Information

Funding Medium

Both the employer and retiree contributions are placed in a trust which is used to pay benefits.

Your Rights Under ERISA

Please see pages 183-184 for a statement of your rights under ERISA.

Medical

General Information

Glossary of Important Terms Used In This Book

Here are definitions of some of the terms we've used.

Actual Charge: The amount a physician or supplier actually bills for providing a medical service or supply.

Approved Amount: The amount Medicare determines to be reasonable for a covered service. It may be less than the actual charge.

Benefit Period: A benefit period begins the first day a person receives care as an inpatient and ends when the person has been out of confinement for the number of days specified by the Program.

Community Mental Health Center: A Community Mental Health Center means a grouping of coordinated facilities, associated with a hospital (or, if not associated with a hospital, approved by the Company or Insurance Company), and which is part of a defined statewide Community Mental Health Program and which meets the definition of a Community Mental Health Center in the Federal Mental Health Centers Acts of 1963.

Convalescent Facility: A Convalescent Facility may also be known as a Skilled Nursing Facility for purposes of this benefit. If you are covered by Plan 1, call the Navistar/Aetna Benefits Office to see if the Facility you want to use will meet the Plan 1 definition of a Convalescent Facility. If you are covered by Plan 2, Medicare will tell you which Facilities are authorized.

Not all Convalescent Facilities will meet Plan 1's definition. A Convalescent Facility must be an institution, or a distinct part of one, that fully meets all of the following tests:

1. It is primarily engaged in, and licensed to provide, skilled nursing services and physical restoration services to patients convalescing on an **inpatient** basis.
   - Skilled nursing services are professional services provided by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N) under the direction of a registered professional nurse.
   - Physical restoration services are those that help a person to achieve a sufficient degree of bodily functioning to permit self-care, and take part in the essential activities of daily life.

2. It is providing those services on a 24-hour-a-day basis, under the full-time supervision of a physician or registered professional nurse with licensed nursing personnel on duty at all times.
3. It maintains a complete medical record on each patient, and has a utilization review plan for all of its patients.
4. It is not an institution that is, other than incidentally, a place for rest, for drug addicts, for alcoholics, for custodial or educational care, for the care of mental disorders, or a place for the aged.

Copayment: The percentage of the charge for covered services shared by you and Navistar, after you meet an annual deductible.

Copayment Maximum: The most you or a covered family member will pay toward medical expenses (after your deductible) during a calendar year. Once you meet your copayment maximum, Plan 1 will pay 100% of covered medical expenses for the rest of that calendar year. Certain expenses, as listed on page 25, do not count toward the calendar year copayment maximum.

Covered Expense: Any necessary, Reasonable and Customary item of expense for services covered in whole or in part under this program, or any other plan in which the covered individual is enrolled. When a plan provides benefits in the form of services, the reasonable cash value of each service is considered to be a benefit paid.

Custodial Care: Care made up of services and supplies that:

- ✔ Are furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide therapeutic treatment; and
- ✔ Can safely and adequately be provided by persons who do not have the technical skills of a physician, R.N., or L.P.N.

Activities of daily living include such things as bathing, feeding and taking oral medicines. Such care is custodial regardless of who recommends, provides or directs the care, where the care is provided, or whether or not the patient can be, or is being, trained to care for himself or herself.

This applies regardless of whether or not a person is totally disabled. (Conditions requiring Custodial Care may, for example, include Alzheimer's disease, senility, or stroke.)

Medical

General Information

Day Care Center: A Day Care Center means a facility associated with a hospital (or, if not associated with a hospital, approved by the Company or Insurance Company) having a professional staff whose primary purpose is to provide a planned program of psychiatric services for patients with mental illness who spend only a part of each day at the Center.

Day Care Treatment Program: A Day Care Treatment Program means a planned program of psychiatric services for ambulatory patients with mental illness who do not require full-time hospitalization, but who are able to reside outside the "Approved Psychiatric Facility" and come to the Facility for treatment. A Day Care Program implies a program of psychiatric services more extensive than a physician's office treatment.

Deductible: The amount an individual must pay toward covered medical expenses each calendar year before the Program begins paying benefits.

Due Date: The date premium payments are due. Always the first day of the month.

Effective Date: The date coverage begins. Always the first day of the month.

Emergency: A medical emergency is the sudden and unexpected onset of, or significant increase in, symptoms which require immediate medical care which the patient seeks promptly after the onset or increase in symptoms, or as soon thereafter as care can be made available.

Excess Charge: The difference between the Medicare-approved amount and the actual charge for a covered service or supply.

Fully Incapacitated (Handicapped) Child: An unmarried, fully incapacitated or handicapped child is one who is unable to earn a living because of a mental or physical incapacity that began before he/she reached age 19 (or age 25, if dependent on you for 50% of his/her support). The child must be incapable of self-sustaining employment.

Medical

General Information

To continue medical coverage past the usual age limits for unmarried children, you will need to provide medical proof that your child is handicapped. Medical proof must be submitted no later than **31 days** after your child's 19th or 25th birthday. You may be asked to provide medical proof of your child's continuing handicap. To do that, your child may need to be examined as long as the handicap continues. These exams may start **two years** after your child's 19th or 25th birthday, but will not be required more than once each year.

Coverage for your handicapped child will stop as soon as:

- ✔ Your child is no longer incapacitated or handicapped.
- ✔ You fail to provide medical proof of a continuing handicap.
- ✔ You do not allow required examinations.
- ✔ Dependent coverage is terminated for your child for any reason other than reaching the age limit.

For more information, contact the Human Resources Department at a Company location near you, or call the Navistar/Aetna Benefits Office at **1-800-435-2969**. Remember, it is your responsibility to contact Navistar and apply for continued coverage once your dependent reaches the limiting age.

Grace Period: The extended period of time **(45 days)** after the statement due date.

Hold Harmless Provision: Navistar has for many years included a Hold Harmless Provision under its health care coverage. Its purpose is to provide necessary assistance when a provider, such as a physician or other provider, charges more than the Reasonable and Customary amount allowed by the Program or when services performed were not medically necessary as determined by the Program. Under this Provision, you are provided with legal assistance to defend against these excessive charges. Navistar or the Insurance Company will take every reasonable action to resolve such disputes without residual payment by you.

Medical

General Information

Hospital: This is an institution that fully meets all of the following tests:

- ✔ It is primarily engaged in providing facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons under the supervision of a staff of physicians. These activities must be performed on an inpatient basis in return for compensation.
- ✔ It continuously provides 24-hour service by registered graduate nursing (R.N.) personnel.
- ✔ It is not (other than incidentally) a place of rest for the aged, drug addicts, or alcoholics, and it is not a nursing home.

A Christian Science Sanitarium, if operated or listed and certified by the First Church of Christ, Scientist, is also considered a hospital, but only for someone admitted for healing (not rest or study) while under the care of an authorized practitioner listed in the *Christian Science Journal*.

Inpatient: An inpatient is a registered, live-in patient of a hospital, treatment facility, or Convalescent Facility.

Intensive Care Unit: This is an area of a hospital that is reserved, specially equipped and staffed for the treatment of critically-ill patients who need continuous and intensive nursing care.

Maintenance care: This is care comprised of services and supplies that are furnished to maintain, rather than to improve, a level of physical or mental function and to provide a surrounding that is free from exposures that can worsen the physical or mental condition involved.

Maintenance drugs: Prescription drugs that assist in the control of a chronic medical condition.

Medically Necessary: A service or supply which is medically necessary for the diagnosis, care, or treatment of the physical or mental condition involved. It must be widely accepted professionally in the United States as effective, appropriate, and essential, based upon recognized standards of the health care specialty involved. In no event will the following be considered medically necessary:

- ✔ Those services rendered by a provider that do not require the technical skills of such a provider.

General Information

- ✔ Those services and supplies furnished mainly for the personal comfort or convenience of the individual, any individual who cares for him/her, or any individual who is part of the family.
- ✔ Those services or supplies furnished to an individual solely because he/she is an inpatient on any day when the individual's physical or mental condition could safely and adequately be diagnosed or treated while not confined.
- ✔ That part of the cost which exceeds that of any other service or supply that would have been sufficient to safely and adequately diagnose or treat the individual's physical or mental condition.

This definition does not include any service or supply listed as an exclusion under this Program.

Medicare: A Federal Health Insurance program for people age 65 or older and certain disabled people.

Medicare-approved Amount: Medicare payments are based on the fee schedule amount for Part B physician and supplier services. It takes into account geographic variation in the costs of medical practice. The Medicare-approved amount is the lower of the actual charge or the fee schedule amount.

Medicare Assignment: Agreement to accept the Medicare-approved amount for covered services and supplies as full payment and to be paid directly by Medicare.

Medigap Insurance: Private insurance specifically designed to supplement Medicare's benefits by filling in some of the payment gaps.

Mental Illness: Only those mental, psycho-neurotic and personality disorders listed in the International Classification of Diseases, of the U.S. Department of Health, Education and Welfare (V. #300-329), as amended.

Necessary and Related Ancillary Services of an Approved Outpatient Psychiatric Facility: The Necessary and Related Ancillary Services of an Approved Outpatient Psychiatric Facility means Room and Board as appropriate, drugs and medications, and other institutional supplies and services which are furnished by the facility as regular institutional care.

Medical

General Information

Night Care Center: A Night Care Center means a facility associated with a hospital (or if not associated with a hospital, approved by the Company or Insurance Company) with a professional staff whose primary purpose is to provide for patients with mental illness who do not require full-time hospitalization, a planned program of psychiatric services during the evening and night period.

Night Care Treatment Program: A Night Care Treatment Program means a planned program of psychiatric services for ambulatory patients with mental illness who do not require full-time hospitalization. The patient is able to spend time outside the "Approved Psychiatric Facility," but is confined in a facility during the night time portion of a calendar day.

Non-occupational Disease: A non-occupational disease is a disease that does not:

- ✔ Arise out of (or in the course of) any work for pay or profit, or
- ✔ In the course of the individual's normal job duties, result in any way from a disease that does.

A disease will be considered non-occupational, regardless of cause, if proof is furnished that the person:

- ✔ is covered under any type of Workers' Compensation law, and
- ✔ is not covered for that disease under such law.

Non-occupational Injury: A non-occupational injury is an accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit.

The bodily injury cannot arise out of, or in the course of, the person's commission of a felony, whether or not the person has ingested or taken alcohol, drugs, or any other chemical substance.

Out-of-Pocket Maximum: The amount an individual or covered family member must pay toward medical expenses each calendar year before the Navistar Plan 1 or Plan 2 begins paying benefits.

Outpatient: A person receiving health care services on an appointment or walk-in basis.

Medical

General Information

Outpatient Psychiatric Facility, Approved: An Approved Outpatient Psychiatric Facility means a Hospital, or a Community Mental Health Center, a Day Care Center or a Night Care Center associated with a hospital (or, if not associated with a hospital, approved by the Company or Insurance Company) and licensed as required by applicable law. An Approved Outpatient Psychiatric Facility will be recognized only if there is a psychiatric physician present in the facility on a regularly scheduled basis who assumes the overall responsibility for coordinating the care of all patients. Services must be available, through the professional staff of the facility, as needed from a psychiatric physician, a clinical psychologist, registered nurse, and a psychiatric social worker. Emergency medical care must be accessible through formal agreement with a hospital or a physician. "Approved Outpatient Psychiatric Facility" does not include institutions or Facilities that are primarily engaged in providing services which are custodial, recreational, social or educational in nature.

Participating Pharmacy: A pharmacy that has a written agreement with ValueRx or Aetna to provide prescription drug service.

Participating Physician/Supplier: A physician or supplier who has agreed to accept assignment on all Medicare claims or other plan claims.

Physician (Legally Qualified): Coverage under this Program is available only if charges are made by a legally qualified physician. This is a practitioner who is licensed under the applicable licensing law, is acting within the scope of his/her license to provide covered services and supplies, and is a:

- ✔ Doctor of Medicine;
- ✔ Doctor of Osteopathy;
- ✔ Doctor of Podiatry;
- ✔ Licensed or Certified Psychologist;
- ✔ Doctor of Chiropractic;
- ✔ Doctor of Dental Surgery, or Doctor of Dental Medicine for covered oral surgery or prescription drugs only.

Also included in this definition is an Authorized Christian Science Practitioner listed in the current *Christian Science Journal* at the time he or she provides service.

Medical

General Information

Premium: The amount you pay each month for yourself and covered adults who participate in the Navistar Retiree Health Benefit Program.

Professional Services of an Approved Outpatient Psychiatric Facility: The Professional Services of an Approved Outpatient Psychiatric Facility means those services provided by psychiatric physicians, psychologists, professional graduate nurses and psychiatric social workers who are employees of the Facility, but may also include those services rendered by a psychiatric physician or a psychologist under an agreement with the Facility.

Psychiatric Physician: One who is duly licensed as a Doctor of Medicine (MD) or a Doctor of Osteopathy (DO), and who specializes in the practice of psychiatric medicine, or if such physician does not specialize in psychiatric medicine, such physician has by reason of training and/or experience a specialized competency in the field of psychiatric medicine so that he/she can render the necessary evaluation and treatment to persons with mental illness.

Psychiatric Services: Psychotherapy and other generally accepted forms of evaluation and treatment of mental illness.

Psychologist:

- ✔ for purposes of psychological testing means a person who is licensed to render psychological testing services under state law where applicable, or in other states is certified for psychological testing by an appropriate professional body, and who, in either case, is trained and experienced in the administration of psychological tests.
- ✔ for purposes of rendering services as a professional staff member of an Approved Psychiatric Facility means a person who is licensed by state law where applicable as a clinical psychologist, or in other states is certified as a clinical psychologist or a consulting psychologist by an appropriate professional body.

Reasonable and Customary: Plan 1 covers only charges that are Reasonable and Customary. The Reasonable and Customary charge for a service or supply is the lower of:

- ✔ The provider's usual charge for furnishing it; and
- ✔ The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

Medical

General Information

In determining the Reasonable and Customary charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers in the area, Aetna may take into account such factors as:

- ✔ the complexity,
- ✔ the degree of skill needed,
- ✔ the provider's specialty,
- ✔ the range of services or supplies provided by a Facility, and
- ✔ the prevailing charge in other areas.

"Geographic area" means the grouping of ZIP codes used to obtain a representative cross-section of similar providers.

Residential and Outpatient Substance Abuse Facility, Approved: An Approved Residential and Outpatient Substance Abuse Facility means a facility which meets all of the following criteria:

- ✔ A Residential or Outpatient Chemical Dependency Treatment Facility must provide a program specifically for chemical dependency problems.
- ✔ A Residential or Outpatient Chemical Dependency Treatment Facility must provide detoxification, if necessary, and rehabilitation services.
- ✔ A Residential or Outpatient Chemical Dependency Treatment Facility must be legally constituted and licensed where required by the state for treatment of chemical dependency and must provide medical services and a specialized treatment program to live-in residents.
- ✔ An Outpatient Chemical Dependency Treatment Facility must be legally constituted and licensed where required by the state for treatment of chemical dependency and must provide medical and other services specifically for the treatment of chemical dependency problems.
- ✔ In no event will the term "Approved Residential and Outpatient Facility" include an institution, or a part thereof, which is used primarily as a rest home, a home for the aged, a nursing home, a sheltered care facility, or a place for the treatment of mental disease.

Medical

General Information

Room and Board: Room and Board charges are an institution's charges for Room and Board, as well as other daily or weekly charges made as a condition of room occupancy.

Semi-private Rate: The semi-private rate is the daily Room and Board charge that an institution makes for the majority of beds in its semi-private rooms containing two or more beds. If the institution has no semi-private rooms, the semi-private rate will be the daily Room and Board rate most commonly charged for semi-private rooms with two or more beds by similar institutions in the area.

- ✔ An "area" means the grouping of ZIP codes used to obtain a representative cross-section of similar institutions.
- ✔ An "institution" is a Hospital, Treatment Facility, Convalescant Facility or a Hospice Facility, depending on the benefit being described under this Program.

Medical

General Information

Your Rights Under ERISA

The Retiree Health Benefit Program is part of the Navistar International Transportation Corp. Retiree Health Benefit and Life Insurance Plan. As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). Specifically, ERISA provides that all Plan participants are entitled to:

- ✔ Examine, without charge, at the Plan Administrator's office and at other specified locations and in the manner required by ERISA, all Plan Documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as the detailed annual reports.
- ✔ Obtain copies of all Plan Documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- ✔ Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension or welfare benefit or exercising your rights under ERISA. If your claim for a pension or welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Medical

General Information

Under ERISA, there are steps you can take to enforce the above rights. For example:

- ✔ if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
- ✔ if you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after using the Plan's appeal process.
- ✔ if it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

If you file a suit, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.